An Examination of the Experiences of Psychiatric Nurses Who Work with Traumatized Individuals

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Abstract

The experience of psychiatric nurses who work with traumatized individuals has received very little research attention in North America, leaving a significant gap in the existing literature. Evidence from other helping disciplines suggests the occurrence of both negative and positive impacts upon professionals who engage with the traumatic material of their clients. Constructs such as vicarious trauma and vicarious post-traumatic growth have been used to describe these impacts. This study aimed to contribute to the limited knowledge of these impacts on psychiatric nurses by using a hermeneutic phenomenological approach to explore their lived experience of working with traumatized individuals. Themes identified from semi-structured interviews with six Registered Psychiatric Nurses (RPNs) were as follows: awareness of trauma prevalence among clients, participants' personal trauma, negative impacts of working with traumatized clients, positive impacts of working with traumatized clients, protective factors, shifts in philosophy of practice, and lack of organizational supports. Sub-themes were further identified under participants' personal trauma, negative and positive impacts of working with traumatized clients, and protective factors. Findings are discussed with attention to the implications for RPNs, psychiatric nursing educators, and employers, and areas for further research are identified. Areas for further research are discussed based on questions that arose from the findings of this study.

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Chapter 1: Introduction

Background

A growing body of literature provides evidence of the staggering prevalence and pervasive impacts of trauma among individuals requiring mental health treatment in North America (Courtois & Gold, 2009; Muskett, 2014). For example, researchers indicate that of individuals seeking treatment for personality disorders, mood disorders, substance use disorders, and other mental health conditions, up to 90% report exposure to significant emotional, physical, and or sexual abuse in childhood (Muskett, 2014). Of those served by the public mental health and substance use services in Canada, trauma rates as high as 90% have also been shown in some populations (BC Provincial Mental Health and Substance Use Planning Council, 2013). When considering these statistics, it is also important to consider that trauma is generally thought to be underreported due to such factors as ongoing threats to safety, privacy concerns, stigma, and shame associated with some traumatic experiences (Andresen & Blais, 2019; Peretti & Cozzens, 1979; van der Wath, van Wyk & Janse van Rensburg, 2013; Wekerle & Kerig, 2017).

In response to the growing awareness of the prevalence of trauma, Trauma Informed Practice (TIP), sometimes referred to as Trauma Informed Care (TIC), has emerged as a key paradigm in healthcare disciplines including nursing (Muskett, 2014). In addition to other guiding principles, TIP recognizes the potential for negative impacts from exposure to clients' trauma for clinicians and service providers, and emphasizes the emotional safety of these professionals (BC Provincial Mental Health and Substance Use Planning Council, 2013). Further, TIP discusses the use of trauma screening and inclusion of trauma history in assessments (BC Provincial Mental Health and Substance Use Planning Council, 2013),

potentially increasing the exposure to trauma material by psychiatric nurses (Gates & Gillespie, 2008).

Psychiatric nurses work closely with traumatized individuals and have a significant role in the delivery of TIP, yet little is known about this aspect of their practice (Hubbard, Beeber & Eves, 2017; Isobel, 2015; Pearson, 2012). This is despite acknowledgement that nurses may be negatively impacted personally and professionally by vicarious exposure to trauma (Beck, 2011; Tabor, 2011), which may contribute to issues of absenteeism and retention (Sheppard, 2015). Additionally, vicarious traumatization on the part of the nurse may negatively influence the therapeutic relationship, and ultimately affect the treatment and care clients receive (Rasmussen, 2005; Robinson, Clements & Land, 2003). The scarcity of research exploring how psychiatric nurses are impacted by their work with traumatized clients is concerning, given their exposure and role in TIP delivery. In her editorial on psychiatric nurses who work with traumatized clients Pearson (2012) wrote:

> The emotional outcomes of vicarious exposure to trauma affect nurses in immediate and long-term ways. The cumulative effect of vicarious traumatization (VT) in nurses who care for these populations over long periods of time has not been measured. How do we identify this risk, mark the insidious nature of the risk, and then effectively manage it within our settings where nurses provide care?... psychiatric nurses, who take care of traumatized individuals of all ages, in multiple treatment settings, are at risk for experiencing trauma symptoms similar to those of their patients (p. 123).

Evidence from other disciplines supports that professionals can experience negative psychological consequences of exposure to their clients' trauma. Constructs such as vicarious trauma (VT), secondary traumatic stress (STS), compassion fatigue (CF), and burnout have been

used to describe and/or explain these effects (Bercier & Maynard, 2015; Collins & Long, 2003; Lerias & Byrne, 2003; Vrlevski & Franklin, 2008). Negative consequences such as these have been linked not only to physical and emotional exhaustion, but can contribute to impaired job performance, absenteeism, and turnover in nurses (Sheppard, 2015).

In addition to mounting evidence of potential negative consequences of secondary trauma exposure, it has also been observed that health care professionals can also experience positive outcomes as a result of their work with traumatized individuals (Arnold, Calhoun, Tedeschi & Cann, 2005; Barrington & Shakespeare-Finch, 2013; Bartoskova, 2017; Pack, 2014). Constructs used to describe these outcomes are vicarious post-traumatic growth (VPTG) (Arnold et al., 2005; Barrington & Shakespeare-Finch, 2013; Bartoskova; Manning-Jones, de Terte & Stephens, 2017), compassion satisfaction (CS) (Figley, 1995; Sheppard, 2015), and vicarious resilience (VR) (Pack, 2014).

Research Objectives

Little is known about the relationship between the seemingly contradictory effects of working with traumatized individuals, or how they are experienced by psychiatric nurses. This study aims to contribute to the existing knowledge concerning these effects on professionals who work with trauma survivors. The findings from this study may also influence psychiatric nursing practice, policy development related to TIP, and psychiatric nursing education, by informing educators and future psychiatric nurses about the risks and benefits of working with traumatized individuals. Further, knowledge gained related to the negative impacts associated with working with traumatized individuals may inform organizational efforts to reduce problems of absenteeism and turnover in psychiatric nurses, and promote their well-being.

Research Question

This research project focused on the lived experience of psychiatric nurses using a qualitative, phenomenological approach to address the research question, *what are the lived experiences of psychiatric nurses who work with traumatized individuals?*

Summary

The prevalence of trauma among individuals receiving treatment for mental health and substance use problems has been well established, and highlights the potential for secondary trauma exposure among psychiatric nurses, who work closely with these individuals. Psychiatric nurses may be at risk of experiencing similar consequences of trauma work reported by other helping professionals, yet their experiences have not been studied adequately. This study aimed to address this gap in the existing literature, and inform efforts to promote the wellness of psychiatric nurses. A review of the available literature was provided in the following chapter, as a basis upon which to contextualize the research problem.

Chapter 2: Review of the Existing Literature

Consistent with the research methodology, a literature review was conducted to inform what is already known about the subject matter, what gaps exist in this knowledge, and to ensure the appropriateness of the selected methodology (Streubert & Carpenter, 2011). Literature served as a contextual framework upon which to analyze the data obtained, rather than as a steering point to direct the research process (Streubert & Carpenter, 2011).

Terminology

While little has been published about the experience of nurses, and even less so on the experience of psychiatric nurses, there is ample evidence of the negative psychological impact upon other professionals who work with traumatized individuals (Bercier & Maynard, 2015; Collins & Long, 2003; Lerias & Byrne, 2003; Vrlevski & Franklin, 2008), with noted similarity to their clients' own trauma-related symptoms (Bercier & Maynard, 2015; Rasmussen, 2005). What has muddied the current literature on the effects of secondary exposure to trauma by mental health professionals, is an acknowledged lack of consistency with respect to the terminology used to describe them (Beck, 2011; Bercier & Maynard, 2015; Collins & Long, 2003; Newall & MacNeil, 2010; Tabor, 2011; Vrlevski & Franklin, 2008; Walsh & Buchanan, 2011). The terms secondary traumatic stress, compassion fatigue, burnout, and vicarious trauma are most commonly used to describe the resulting psychological impact of exposure to others' trauma, despite discernable differences in their meanings (Newall & MacNeil, 2010; Vrlevski & Franklin, 2008).

Figley (1995) conceptualized secondary traumatization or secondary traumatic stress (STS) as the behavioral and emotional results of exposure to traumatic events experienced by significant others, and the stress experienced by helping the victims of those traumatic events.

The original post-traumatic stress experienced by the victim is essentially passed onto the therapist or care provider (Figley, 1995), and mirrors the symptoms of PTSD (Newall & MacNeil, 2010). These include intrusive thoughts, memories or nightmares associated with client trauma, sleep disturbance, irritability or angry outbursts, fatigue, difficulty concentrating, avoidance of clients, and hypervigilant or startle reactions toward reminders of client trauma (Newall & MacNeil, 2010).

Similarly, compassion fatigue (CF) is defined by Figley (1995) as reduced capacity or interest in being empathic or bearing the suffering of clients experienced by formal caregivers as a result of knowing about a traumatizing event or suffering of a person. CF is often used interchangeably with secondary traumatization (Newall & MacNeil, 2010; Sorenson, Bolick, Wright & Hamilton, 2017). Figley (1995) proposed a movement away from the term secondary traumatization to CF as he felt healthcare professionals may receive it more favorably (Walsh & Buchanan, 2011). Since its early adoption, the concept of CF has undergone further investigation and clarification from other authors and researchers (Sinclair, Raffin-Bouchal, Venturato, Mijovic-Kondejewski & Smith-MacDonald, 2017; Sorenson et al., 2017), and has notably been criticized for lacking validity as a construct, as well as its implication that compassion is lost in the process of caring for traumatized individuals (Sinclair et al., 2017). “The suggestion that compassion fatigue is inextricably linked to the construct of compassion is problematic, as it implies there is something inherently tiring about compassionate feelings and behaviours, and that healthcare providers’ capacity for compassion is limited or depletes over time” (Sinclair et al., 2017, p. 13). Despite criticism and lack of consistency about its definition however, “[t]he common theme through all of these changes is that CF is the emotional cost of caring for traumatized individuals or bearing witness to others’ trauma” (Sorenson et al., 2017, p. 558).

Some of the common symptoms of CF include: preoccupation, reexperiencing or dreams of the secondary trauma material or event, avoidance of thoughts, feelings or activities that serve as reminders of the material or event, social detachment, decreased interest in activities, sleep disturbance, reduced concentration, and irritability (Figley, 1995). CF has also been characterized as a syndrome that combines aspects of secondary traumatic stress and professional burnout, and is distinguished from STS and vicarious trauma by its cumulative and gradual impact as opposed to immediate onset (Newall & MacNeil, 2010).

Vicarious trauma (VT) is a term coined by McCann and Pearlman (1990) that describes a cumulative process of negative transformation that occurs in individuals as a result of working with trauma survivors. Symptoms of VT often represent "disruptions in both self and professional identity, worldview, spirituality, abilities, and cognitive beliefs particularly in the areas of safety, trust, esteem, intimacy, and control" (Vrlevski & Franklin, 2008, p. 106). In contrast to Figley's conceptualization of secondary traumatization and compassion fatigue, which focused on external symptoms, VT describes the internal experiences of therapists, and the gradual and longer lasting changes in self they experience as a result of their exposure to their clients' trauma (Ben-Porat & Itzhaky, 2009). "It is helpful to think of vicarious traumatization and secondary traumatic stress as two different disorders with similar features, which may occur either independently of each other or as co-occurring conditions" (Newall & MacNeil, 2010, p. 61).

The theoretical underpinning of the concept of VT is constructivist self-development theory (CSDT) (Pearlman & Saakvitne, 1995 as cited in Devilly, Wright & Varker, 2009), which "attempts to understand an individual's adaptation to trauma as an interaction between personality, personal history, the traumatic event and its social and cultural context" (Devilly et

al., 2009, p. 374). CSDT maintains that the meaning associated with a traumatic event is based on the individual's experience of it, and that this meaning can shift as new ideas and experiences are integrated into the existing beliefs and systems of meaning (Devilly et al., 2009). It is proposed that professionals working with traumatized individuals experience, as a result of chronic exposure to trauma content and its impact on clients, similar transformative changes (Devilly et al., 2009). Williams, Helm and Clemens (2012) argued that "[w]ith its basis in CSDT, VT is a unique construct that differs conceptually from such forms of practitioner impairment as countertransference, burnout and compassion fatigue" (p. 135).

Tabor (2011) also posited that VT has been erroneously used interchangeably with terms such as burnout, compassion fatigue and secondary trauma, and that it is a phenomenon unique to professionals working with individuals with a history of trauma and/or violence. This differs from burnout, which is related to workplace environment and can occur in people who are not exposed to traumatic events or material in their work, and tends to emerge gradually in response to cumulative stress (Figley, 2002; Harrison & Westwood, 2009; Tabor, 2011). Burnout is associated with emotional exhaustion, however, it is more related to the cumulative effects of stressors of a job, particularly when one believes that there are not enough resources to meet the needs of the job. Likewise, compassion fatigue has been used to refer to exhaustion as a result of feelings of sympathy or sadness and a desire to take away another person's suffering, however is not specific to traumatized client populations (Newall & MacNeil, 2010). Secondary traumatic stress is differentiated from VT in that it is a term that can also be used to describe repeated exposure to a single trauma, resulting in revictimization on the part of the original victim, not others (Tabor, 2011). Vrklevski and Franklin (2008) point out that countertransference is not specific to working with traumatized individuals either. They further note the most significant

difference between VT and its identified counterparts is the focus on shifts in cognitive schemas in addition to the more obvious symptoms of distress. Cunningham (2003) also supports VT as a unique phenomenon and posits that "neither countertransference nor burnout alone adequately accounts for the impact on the clinician of the graphic material presented by the traumatized client" (p. 451).

Despite lack of clarity and consistency in the current literature pertaining to the impact on professionals who work with traumatized individuals, "all of these terms reflect a potential impact on nurses related to caregiving that comes from their empathetic interactions with suffering or traumatized patients" (Dominguez-Gomez & Rutledge, 2009, p. 200). Underpinning all these terms is the theoretical construct of stress, which is described by Lazarus and Folkman (1984) as a process of "constantly appraising the environment in an attempt to discern the meaning and significance of events in order to categorize interactions within their environment related to their well-being" (as cited in Walsh & Buchanan, 2011, p. 351). This process allows individuals to determine whether a situation is stressful, i.e. potentially harmful, and whether they have the resources or ability to cope with the situation (Lazarus & Folkman, 1984).

Current Evidence of the Effects of Working with Traumatized Individuals

Research on the experience of psychiatric nurses who work with traumatized individuals is scant, despite the high rate at which they are exposed to the trauma of their clients (Abendroth & Flannery, 2006; Adams, Boscarino, & Figley, 2006; Beck, 2011). Most of the available research has focused on nurses working in oncology, emergency, forensics, and hospice settings (Beck, 2011), and only two North American studies could be found that focused on the experiences of psychiatric nurses who work with trauma victims.

In 1999, 295 RPNs responded to a survey carried out by Robinson et al. (2003) in Manitoba, Canada to determine the prevalence of burnout and vicarious trauma among this population, and to identify predictors of these phenomena. Notably, RPNs in this study showed very high levels of emotional exhaustion in comparison to other mental health professionals, yet also demonstrated very high levels of personal accomplishment. Vicarious trauma rates were found to be comparable to other mental health professionals, and of those RPNs who reported past or active work with trauma survivors, 21% reported re-experiencing symptoms of PTSD, 30% met diagnostic criteria for arousal symptoms of PTSD, and 6% met criteria for avoidance symptoms. Additionally, 59% of these respondents identified their symptoms as interfering in their lives (Robinson et al., 2003).

Important findings regarding predictors of VT among this population were also established. For example, RPNs who felt equipped with the necessary skills to work with trauma survivors, and had access to peer support and ongoing education were less likely to have high levels of VT (Robinson et al., 2003). Further, elements of burnout such as low sense of personal accomplishment and high levels of emotional exhaustion were positively correlated to higher VT scores, yet findings supported VT and burnout as separate, yet related constructs (Robinson et al., 2003).

Hubbard et al. (2017) carried out a directed content analysis of nursing notes utilized in a previous study, with the goal of validating five key components of the concept of secondary traumatization: exposure, vulnerability, empathic engagement, reaction, and transformation. While the authors point out that this methodology is flawed due to “an inherent bias toward finding validation only for the concepts of interest” (p. 125), the study is the one of the few that have utilized a sample of psychiatric nurses. The authors identified both negative and positive

themes within the documentation of psychiatric nurses who were working with traumatized mothers.

> The negative trajectory was one in which the nurse's worldview was altered unfavorably and may be characterized by desensitization, burnout, or negative coping expressions. The positive trajectory was one in which the nurse experienced a transformation due to the integration of a new and different perspective achieved through the empathic engagement with the mother (Hubbard et al., 2017, p. 123).

The authors suggested that the five elements of secondary traumatization as examined in the study, occur continuously, overlapping with one another and ultimately influence the psychiatric nurses' perspective and experience as being either a "sustained negative outcome" or "sustained positive outcome" (Hubbard et al., 2017, p. 124). They also concluded that the therapeutic relationship between the psychiatric nurse and client was influential in determining this outcome. "The quality of the engagement appeared to guide the flow and direction of the process and its potential outcome for ST" (Hubbard et al., 2017, p. 123).

Outside of North Amercia, Mangoulia, Koukia, Alevizopoulos, Fildissis and Katostaras (2015) conducted a quantitative study of psychiatric nurses in Greece to determine the prevalence of secondary traumatic stress, compassion fatigue, burnout and compassion satisfaction, however working with traumatized individuals was not the exclusive focus of this study when determining the impact and prevalence of these experiences. Rather, the researchers considered the totality of psychiatric nurses' experiences, including direct victimization of violence. The researchers nevertheless reported that almost 50% of psychiatric nurses and psychiatric nursing assistants were at high risk for burnout, and 40% were at high risk for compassion fatigue.

A similar study was conducted in Iran by Tirgari, Forouzi, and Ebrahimpour (2019). Using a cross-sectional, correlational design, these researchers examined the relationship between PTSD and professional quality of life (ProQOL) among psychiatric nurses. While the researchers provided evidence of moderate PTSD, burnout, compassion satisfaction, and compassion fatigue among a sample of psychiatric nurses, as well as a relationship between PTSD and all domains of ProQOL (Tirgari et al., 2019), secondary or vicarious trauma exposure was not the specific focus of this study. It was again left open for interpretation what practice-related factors contribute to negative impacts and/or ProQol.

Outside of the psychiatric nursing specialty, findings from acute care nurses who have been exposed to secondary trauma have included shock and distress associated with the trauma and suffering of their patients, sleep problems, distractibility, depression, anxiety, distancing as a coping strategy, feelings of guilt, helplessness, and dissonance in core beliefs about the self (Walsh & Buchanan, 2011). Dominquez-Gomez and Rutledge (2009) reported 33% of a sample of ER nurses met the criteria for secondary traumatic stress, and Sheppard (2015) found 74% of nurse practitioner students had moderate to high levels of secondary traumatic stress. Finally, Dunkley and Whelan (2006) reported a prevalence rate of VT in 45.9% of a sample of telephone counselors. Symptoms identified in those exposed to traumatic material in the context of a therapeutic relationship include affective changes such as sadness, feelings of hopelessness, emotional detachment or increased emotionality, anxiety, anger, as well as nightmares, intrusive thoughts and images, relationship difficulties, and changes in cognitive schemas (McCann & Pearlman, 1990; Williams et al., 2012).

Literature that addresses the link between the negative consequences for nurses who work with traumatized individuals and workplace issues such as absenteeism and turnover is again

limited. However, qualitative research conducted by Sheppard (2015) found that nurses experiencing compassion fatigue exhibited avoidance behaviours such as requesting a transfer to a different clinical area, quitting their position and taking one in another practice area, leaving their position to obtain higher education, or leaving the profession of nursing altogether.

Literature pertaining to the potential positive impacts for nurses who work with traumatized individuals is also limited. Mangoulia et al.'s (2015) study found lower levels of VPTG dimensions of 'new possibilities' and 'personal strength' in psychiatric nurses as compared to community nurses. As mentioned previously, Robinson et al.'s (2003) study showed higher levels of personal accomplishment among their sample of RPNs as compared with established levels among other mental health professionals. Researchers using a mixed methods approach explored the experience of labor and delivery nurses who cared for women during traumatic births reported a moderate amount of VPTG, particularly in the areas of appreciation of life, relating to others, personal strength, spiritual changes, and new possibilities (Beck, Eaton & Gable, 2016). While Sheppard (2015) found significant rates of secondary traumatic stress among a sample of nurse practitioner students, 71% of the same sample also had moderate to high levels of compassion satisfaction.

Among counselors and trauma therapists, several authors (Arnold et al., 2005; Barrington & Shakespeare-Finch, 2013; Bartoskova, 2017) identified benefits such as greater self-awareness, spiritual growth and appreciation for life, improved relationship skills, appreciation for the resilience of people, and satisfaction from witnessing growth in clients and participating in the healing process.

Knowledge regarding the relationship between the negative and positive effects of working with traumatized individuals is in its early stages of discovery. Pack (2014) suggested

that resilience in trauma professionals may develop *after* an initial negative reaction, and that VT is the required precursor for this "bouncing back" process which involves searching for meaning. In contrast, other authors have suggested that VT and VPTG are parallel processes that can occur simultaneously (Calhoun & Tedeschi, 1999; Harrison & Westwood, 2009; Hubbard et al., 2017). Cohen and Collens (2013) therefore point to the limitations of studying negative or positive impacts of trauma work in isolation from one another. Consistent with this advice and the phenomenological approach, the totality of the experience is the focus of the current study (Streubert & Carpenter, 2011). Constructs such as VT and VPTG are used to provide context to the natural evolution of findings based on the unique experience of the participants, and are considered together as an integrated whole (Streubert & Carpenter, 2011).

Little is known about the potential variables that make some professionals more susceptible to VT than others. For example, inconsistency is noted in results on potential confounding variables of personal trauma history and years of clinical experience as they related to levels of VT (Devilly et al., 2009). Some studies demonstrate a higher susceptibility to VT among therapists with a personal history of trauma (Pearlman & MacIan, 1995; Cunningham, 2003; Vrlevski & Franklin, 2008; Williams et al., 2012), however others do not support this theory (Dunkley & Whelan, 2006; Schauben & Frazier, 1995). Likewise, some studies have found higher rates of some aspects of VT among less experienced professionals (Bell, Kulkarni & Dalton, 2003; VanDeusen & Way, 2006), while other results have been inconclusive on this subject (Australian Commonwealth, 2007).

There is also an absence of studies that address the prevention of negative outcomes, and/or assess the effectiveness of interventions on VT (Bercier & Maynard, 2015). "Although there has been a priority on developing and rigorously assessing trauma interventions for those who directly experience various types of trauma, it appears that little effort is being made to

rigorously test interventions to help the helpers" (Bercier & Maynard, 2015, p. 87). While interventions such as individual or group therapy, debriefing, and general self-care strategies are suggested, they have not been tested empirically (Bercier & Maynard, 2015). Correlation between access to peer support and education and lower VT scores among RPNs in Robinson et al.'s (2003) study lends support to these as protective factors, however specific interventions were not examined in-depth. In their meta-analysis, Bercier & Maynard (2015) identified a finding from one study that supported group psychological debriefings in reducing the effects of VT in ER care providers (Everly, Boyle & Lating, 1999), however the study used a small sample of 10 participants, and the meta-analysis itself did not include information regarding search criteria and coding process (Bercier & Maynard, 2015). The effectiveness of education or training on VT for professionals has been studied only on a cursory basis despite it frequently being discussed as a recommendation **(**Dominquez-Gomez & Rutledge, 2009; Newell & MacNeil, 2010; Pack, 2014; Tabor, 2011), and is identified as an area in need of further enquiry (Dominquez-Gomez & Rutledge, 2009; Dunkley & Whelan, 2006).

Summary

The existing literature that addresses consequences of secondary trauma exposure among psychiatric nurses is extremely limited. Evidence from other nursing specialties and related disciplines such as counselling and social work, suggests that both positive and negative outcomes can occur, however little is known about possible variables of influence. The relevance of the current study is well-supported by researchers who acknowledge the need to examine the experiences of psychiatric nurses to identify risks and potential mitigating factors associated with their work with trauma survivors. Qualitative exploration of psychiatric nurses' experiences will provide rich data to add to this knowledge.

Chapter 3: Research Design

As little is known about the experiences of psychiatric nurses who work with individuals with trauma, it was the goal of this researcher to obtain first-hand, detailed accounts of their experiences. As such, a qualitative study was undertaken to appropriately address the research question.

Methodology and Philosophical Underpinnings

The researcher employed a hermeneutic phenomenological approach in order to capture rich descriptions of the lived experience of psychiatric nurses who work with traumatized individuals (Streubert & Carpenter, 2011). Phenomenology is a philosophical or theoretical perspective and research approach grounded in the belief that reality is subjective and based on one's lived experience, rather than being determined by an objective and/or external, physical reality (Cohen, Manion & Morrison, 2011; Streubert & Carpenter, 2011). Thus, it accepts the premise that we "live in a world of multiple realities" (Cohen at al., 2011, p. 19) and sets out to describe phenomena as people experience them in their everyday lives (Sloan & Bowe, 2014).

Hermeneutic phenomenology is an interpretive branch of phenomenology grounded in hermeneutics, which is the understanding of phenomena and their (sometimes hidden) meaning through the interpretation of words and language (Sloan & Bowe, 2014; Streubert & Carpenter, 2011). Central to the hermeneutic phenomenological approach is the belief originating with philosopher Martin Heidegger (1962 as cited in Sloan & Bowe, 2014) that understanding another's experience cannot be achieved in absence of influence from the observer. It is therefore impossible to bracket out the observer's own perceptions or identification with the "essence of a phenomenon" (p. 1294), which is integral to the meaning of experience (Sloan & Bowe, 2014; Streubert & Carpenter, 2011).

Consistent with the aim of the researcher, hermeneutic phenomenology is a useful methodology to answer questions relating to the meaning of phenomenon, with the ultimate goal of understanding the human experience (Crist & Tanner, 2003). It is also an appropriate methodology for researchers who have personal connection or experience with the topic of study, encouraging empathic engagement with the data to aid in its analysis through a process of reflexivity (Sloan & Bowe, 2014). Given that the researcher is an RPN with experience and interest in working with traumatized individuals, this approach is well-suited for this study. Further, the interpretation of meaning central to hermeneutic phenomenology lends itself well to the exploration of complex experiences related to the topic of focus. The phenomena of VT and VPTG are rooted in constructivist self-development theory (McCann & Pearlman, 1990), which posits that individuals construct their own realities through their beliefs, assumptions, and expectations, leading to the development of cognitive schemas through which experiences are interpreted (Cohen & Collens, 2013). In essence, hermeneutic phenomenology invites parallel interpretation of meaning on the part of participants, inviting them to explore their perceptions and meaning of their experiences in caring for traumatized individuals, and also considers the interpretation of the researcher.

Procedural Steps

Recruitment and sampling.

Purposeful sampling was used to recruit RPNs who have experience with the phenomena of interest in order to enhance the richness of the data (Streubert & Carpenter, 2011). Recruitment was conducted through advertisement in the College of Registered Psychiatric Nurses of British Columbia's (CRPNBC) newsletter in order to attract participants from a variety of employment areas. A general call for interest included a brief description of the

research topic and methodology and time commitment, and requested that interested RPN's in BC with experience working with individuals with trauma histories respond to the researcher directly via e-mail (see Appendix A). Upon making initial contact, preliminary e-mail communication was conducted during which more detailed information about the study was offered, and intent to participate was confirmed (Streubert & Carpenter, 2011). For a sample follow-up e-mail, please refer to Appendix B.

Participants.

A total of six RPNs were interviewed for this research. All self-identified as female gendered and ranged in age from 37 to 64. The participants had a range of experience as an RPN from seven to forty years. All had worked in a variety of healthcare settings (average seven) during their careers, the most common being adult inpatient psychiatry, adult community mental health, and substance use or concurrent disorders. Half of the participants continue to practice in more than one role. All six participants were prepared at a baccalaureate level, and two participants held Masters degrees. See Appendix C for demographic data collection tool.

Data collection.

Data was collected via audio recorded, semi-structured, face-to-face interviews. Prior to the initial interview, written informed consent was obtained (see Appendix D), and process consent was used intermittently to confirm ongoing willingness to participate (Streubert & Carpenter, 2011). Interviews were conducted at a private, mutually agreeable location or via video conferencing. Questions were intentionally broad in order to capture each participant's story and avoid steering the direction of the interview, for example, "How have you been affected by your work with clients who have experienced trauma?". Consistent with findings from Hyatt-Burkhart (2014), who noted participants only addressed positive impacts of trauma

work when prompted, participants were asked, "What if any positive impacts has this work had on you?". See Appendix E for a complete interview guide. Interviews were conducted until saturation of data was achieved, meaning interpretations gathered were clear and no new themes or meanings were emerging from continued interviews (Crist & Tanner, 2003; Streubert & Carpenter, 2011). Hand-written field notes were taken by the researcher during interviews to record observations and relevant non-verbal behaviours not captured by audio-recording, and interviews were transcribed by the researcher to enhance accuracy and promote the researcher's engagement with the data (Streubert & Carpenter, 2011).

Data analysis.

Consistent with the methodology, data analysis occurred together with data collection. In this "circular process, narratives are examined simultaneously with the emerging interpretation, never losing sight of each informant's particular story and context" (Crist & Tanner, 2003, p. 203). This entailed listening to each interview, transcribing, re-listening to each interview, and making hand-written notes regarding areas that were emphasized or had or particularly relevance to the participants' experience. Analysis of transcripts and field notes were conducted using Crist and Tanner's (2003) framework, which outlines five phases for hermeneutic phenomenological interpretation. Phase one involved reviewing transcripts of the interviews and examining them to identify missing pieces or questions and guide the remaining interviews. During phase two, emerging themes were identified and written repeatedly to form interpretations of meaning, and salient excerpts from the interviews were highlighted. Phase three involved review of interpretive summaries from each interview, with the intent to find common meanings and connections between meanings. These were color coded and broken into themes and sub-themes, which were shared and discussed with the thesis advisor. In the fourth phase, more in-depth

interpretations were made of the preceding summaries and comparisons. Each participant was contacted by e-mail and provided a summary of paraphrased and direct quotes to be used in the manuscript in order to verify their accuracy. Permission was obtained from all participants to have these statements included in the final manuscript. Finally, in phase five the final manuscript of the research was completed. An audit trail was kept during all phases of the analysis to ensure trustworthiness of the data (Crist & Tanner, 2003; Streubert & Carpenter, 2011). The researcher engaged in a process of self-reflection throughout the research process to promote awareness of her relationship to the data, and how the shared experience of herself and the participants may impact the interviews themselves as well as interpretation of the data.

Protection of Participants and Ethical Issues

The researcher recognizes the unpredictable nature of ethical issues that may arise while undertaking qualitative research due to its "open, emerging nature" (Streubert & Carpenter, 2011, p. 62), and the potential for the topic of study to elicit sensitive issues and emotions among participants. Preparation was therefore made to ensure appropriate supports such as counseling were available to participants who may experience distress as a result of their involvement in the proposed study, and the roles and boundaries of the relationship between the researcher and participants were clarified at the outset of the study (Streubert & Carpenter, 2011). Included with the consent form, participants were given a list of counseling resources in each of the province's health authorities. Further, process consent was utilized to promote the ethical principle of autonomy, and interpretations and salient quotes were reviewed with participants for validation (Streubert & Carpenter, 2011). Confidentiality and anonymity of participants was protected by conducting interviews in private, mutually agreed upon locations, securing data in a locked cabinet in the researcher's secured office at Douglas College in Coquitlam, B.C, and obtaining

permission to use any direct quotes in the completed manuscript (Streubert & Carpenter, 2011). Lastly, ethics approval was obtained from Brandon University Research Ethics Committee (BUREC) on July 12, 2018 (see Appendix F).

Chapter 4: Emergent Themes

Data analysis resulted in the identification of seven central themes: awareness of trauma prevalence among clients, participants' personal trauma, negative impacts of working with traumatized clients, positive impacts of working with traumatized clients, protective factors, shifts in philosophy of practice, and lack of organizational supports. Sub-themes were further identified under participants' personal trauma, negative and positive impacts of working with traumatized clients, and protective factors. Under participants' personal trauma, three sub-themes emerged: personal trauma as influencing the decision to become an RPN, vulnerability towards being personally triggered, and personal trauma as enhancing RPN practice. In relation to the negative effects of working with traumatized individuals, the following seven sub-themes were identified: changes in relationships, feelings of frustration, helplessness and hopelessness, transfer of emotional pain, difficulty leaving trauma at work, functional changes, and effects on employment status. Under the theme of positive effects of working with traumatized individuals, four sub-themes were identified: recognizing resiliency, feeling rewarded, improved personal relationships, and increased empathy and reduced judgment. Finally, under protective factors, sub-themes were identified as self-care and seeking support. See Table 1 for a summary of emergent themes and sub-themes.

Table 1
Summary of Emergent Themes

Themes	**Sub Themes**
1) Awareness of trauma prevalence among clients.	
2) Participants' personal trauma.	a. Personal trauma as influencing the decision to become an RPN. b. Vulnerability towards being personally triggered. c. Personal trauma as enhancing RPN practice.

3) Negative impacts of working with traumatized clients.	a. Changes in relationships b. Feelings of frustration, helplessness and hopelessness c. Transfer of emotional pain d. Difficulty leaving trauma at work e. Functional changes f. Effects on employment status
4) Positive impacts of working with traumatized clients.	a. Recognizing resiliency b. Feeling rewarded c. Improved personal relationships d. Increased empathy and reduced judgment.
5) Protective factors.	a. Self-Care b. Seeking support.
6) Shifts in philosophy of practice.	
7) Lack of organizational supports.	

Awareness of Trauma Prevalence among Clients

When asked about their exposure to clients who have experienced trauma, all six participants indicated the majority of the clients they have worked with in psychiatric nursing practice have a history of trauma, with half of the participants estimating 100% prevalence in some client populations. Some participants discussed this awareness as developing gradually throughout their psychiatric nursing careers, recognizing it more in retrospect than at the time. This was attributed to a lack of recognition or acknowledgment of the presence of trauma within the client population amongst treatment providers. For example, Participant #2 stated, "when I started practicing we even didn't mention trauma". She further described that earlier in her psychiatric nursing career she tended to rely on a diagnosis such as post-traumatic stress disorder (PTSD) to alert her to the presence of trauma, as it wasn't typically discussed outside of the context of this diagnosis. It wasn't until she sought out more education and understanding of trauma and TIP that she began to recognize its influence among the client population at large.

Participant #3 also described that in her early career working in acute psychiatry, she developed an awareness of trauma history among her clients as a result of their sharing small

"fragments" in conversation, but noted that trauma was not often acknowledged or discussed in any detail in this setting. Similar to Participant #2, it was as a result of her own interest and purposeful seeking out of more knowledge about the impacts of trauma, that she became more aware of it as a significant influence among the clients she was seeing in practice. She reflected that seeking out knowledge and experiences working with other professionals allowed her to gain more expertise in working with traumatized individuals. "Going to colleagues and going to a supervisor and eventually going to the psychiatrist themselves who were doing these kinds of things, was one of the only ways I found that I could do it… I was able to go out and seek more learning and kind of more coaching and more stuff from the psychiatrist as well as the psychologist."

Participant #5 echoed this experience, stating that early in her career she found that trauma was not addressed, and that she was discouraged by colleagues from giving clients the opportunity to open up about their traumatic experiences. She further noted early in her career as an RPN within the healthcare system "there was a lot of stigmatization; pervasive stigmatization about individuals who have experienced trauma. In other words, 'oh they're borderline, don't give them airtime, that person has an eating disorder and they're manipulative, set some strict boundaries'".

Participant #6 also identified that despite a high percentage of trauma amongst the adolescent treatment population she worked with early in her career, trauma was not a central focus of care within the RPN role. In this agency, disclosures of trauma were handled by documenting the disclosure on the patient's chart, at which time another professional such as a counselor or social worker may follow up.

Participants' Personal Trauma

While personal trauma history of participants was not a focus of the current research, nor was it asked about during interviews, four of the six participants interviewed spontaneously mentioned their own trauma as influencing their work with traumatized individuals in some manner. Three sub-themes emerged during analysis of these disclosures: a) personal trauma as influencing the decision to become an RPN, b) increased vulnerability towards being triggered in the context of working with traumatized individuals, and c) personal history of trauma as enhancing RPN practice.

Personal trauma as influencing the decision to become an RPN.

Three participants identified a link between the choice to pursue a career in psychiatric nursing and past trauma. Participant #1 identified a belief that psychiatric nurses "are generally attracted to the work because they've been traumatized". This belief was shared by Participant #2, who stated, "[i]t's not unusual that many people who end up in healthcare, including RPNs have their own trauma experience, so it's like a collective experience that in a sense, in many cases maybe brought us to this profession". Participant #3 identified her own personal trauma history as influencing her decision to enter psychiatric nursing as a profession. "[O]ne of the reasons I went into psychiatric nursing myself, is my mother was institutionalized in a large psychiatric institution for most of my life and there was a lot of violence in my own home".

Personal trauma as increasing vulnerability towards being triggered.

Two of the four participants who spontaneously discussed their own trauma history identified it as increasing propensity to be emotionally triggered while working with trauma survivors in the context of RPN practice. Participant #2 described this as occurring occasionally, and noted a need to acknowledge and process these triggers in order to reduce their effects.

> I have to admit that part of it is that being exposed to client's trauma it kind of is effecting my personal trauma that I needed to process for myself. So in a sense I supposed there is a little bit of self-injury, not necessarily self-inflicted, but this is kind of a weak spot and from time to time I get a little kick and I need to process it again.

Similarly, Participant #3 described her own past trauma of living with a family member plagued by mental illness as a trigger in working with traumatized individuals. For example, after witnessing the trauma of a patient being taken forcefully into an ambulance to be admitted to hospital she described, " I got back and I went into my office and I closed the door. And I lost it, for the very first time in all my years… it hit me like you would not believe". She also noted that when clients would open up about their traumatic experiences it sometimes led her to consider her own past experiences and the lack of support she had in dealing with them. "Once people started telling me about that it would also draw on what I was feeling, and how much more I could have used or how much better it could have been for me if somebody was able to access that information more quickly and more easily".

Personal trauma history as enhancing RPN practice.

All four participants who discussed their trauma history expressed that their own personal trauma has impacted their psychiatric nursing practice in a positive manner. Participant #1 identified her own exposure to trauma in childhood as contributing towards enhanced empathy or understanding of her clients' traumatic experiences. "I always had empathy and I had an idea of what they would go through and we would talk about it". Participant #2 conceptualized her personal trauma as potential source of professional strength. "So I needed to find elements of my past trauma that actually are sources of strength, and this is what I can utilize as an RPN". Participant #3 described how she drew upon her own traumatic experiences in childhood as a source of understanding the needs of her own clients. She described how this propelled her

interest in trauma, and her quest for more knowledge and training in addressing it. Participant #5 described that in the context of her role as an RPN she had the opportunity to formally share her own lived experience of trauma across professional venues as an effort to dispel the stigma associated with trauma, and promote a philosophy which reduces the power differential between clients and professionals. In addition to promoting her own healing, this experience influenced her sense of connection with clients in practice, meeting them on a human to human level rather than on an "expert" versus patient level.

Negative Impacts of Working with Traumatized Clients

All six participants acknowledged at least some negative impacts on them as a result of working with traumatized individuals, even if these impacts were not enduring. These negative effects were categorized under six sub-themes that emerged from the data: a) changes in relationships, b) feelings of frustration, helplessness and hopelessness, c) transfer of emotional pain, d) difficulty leaving trauma at work, e) functional changes, and f) effects on employment status.

Changes in relationships.

Four of six participants identified negative changes in their personal relationships as a result of their work with traumatized individuals. In the context of describing the cumulative effects of trauma exposure in the workplace, Participant #1 described a tendency towards social isolation, and also described becoming more "controlling" in her personal relationships, which she attributed to feeling out of control at work. She further described losing friendships and being shunned from colleagues as a result.

Participant #3 spoke specifically about her marital relationship as being negatively impacted by her work with traumatized individuals. She described this in connection to sub-

theme d (difficulty leaving trauma at work), having difficulty connecting romantically while feeling burdened by the traumatic material she was exposed to, which contributed to the disintegration of her relationship, although it was not the only factor.

Participant #4 described that when she was exposed to traumatic material that was particularly upsetting to hear, she found it more difficult to be around others socially. Participant #6 also endorsed becoming more "internalized" over time, not wanting to engage with or listen to others when she is dealing with something difficult at work, and described herself as quieter in social situations when she is impacted by a client's trauma.

Participants #4 and #6 also described some shift in their empathy towards others in their personal lives as a result of exposure to traumatic material at work. Participant #4 spoke about how the increased perspective of people's life experiences as a result of working with trauma survivors conversely serves as a "bad thing" in that issues that arise with peers are minimized in comparison to those faced by clients, as such leading to reduced empathy. "Sometimes too much perspective is…you know you stop taking things seriously when it's serious for somebody. When somebody thinks something in their life is really serious and it doesn't feel that serious". Participant #6 similarly endorsed having reduced compassion for those in her personal life experiencing a comparably mild stressor as a result of exposure to traumatic material. She questioned if this was simply a personality characteristic unrelated to her professional role, or an attempt to distance herself because she "doesn't want to get involved with their stuff" after taking on so much emotionally charged material at work.

Frustration, helplessness, and hopelessness.

When asked to describe the experience of working with traumatized individuals, frustration, and/or a sense of helplessness, or hopelessness were expressed by all participants. These feelings stemmed from lacking the skills, time, or resources necessary to adequately

support clients with trauma histories, creating a sense that the traumatized client was being let down. Participant #1 discussed the financial barriers faced by her clients who could not afford to get treatment from a psychologist, for example. She also described frustration stemming from competing workplace demands in an inpatient psychiatry setting, such that her ability to respond to trauma disclosures was impacted. "I'd have to interrupt their opening up and talking to me, so the interviews are getting shut down and then they know these interactions are short so they just don't talk about it anymore".

Participant #2 discussed how her growing awareness of the prevalence of trauma and its impacts led her to feel hopeless and helpless about her ability to impact change.

> I think hopelessness because of the role we play. We are not just people who are passive in receiving the information. But then the question is, so what? What are we going to do about it? And the very first reaction is like, I have no idea.

Participant #2 went on to say that frustration often follows this sense of hopelessness when despite her best intentions to provide empathy, support and be inclusive in her approach, "it doesn't seem to make much difference" and describes the process of healing from trauma as a "tedious and very long process". While she is able to understand trauma as the root cause of clients' dysfunction or maladaptive behavior patterns, she questions her ability to make a difference or affect change. She reflected:

> And many times the dysfunction that is stemming from trauma remains dysfunction because it's known, because it's comfortable, because it serves a protection. And any change basically requires some risk taking. And many of the clients that I'm working with don't feel comfortable with taking more risks…I really genuinely understand, I mean I haven't walked in this individual's shoes, but I understand the root of their

behaviors or dysfunctions and I don't know if I can help; like I don't know if I can really make a difference or have an impact.

Participant #3 also described feeling frustrated that she was not able to play a more significant role in healing or working through the "trauma piece" with clients when working as an inpatient psychiatric nurse early in her career. Despite being aware of the relevance of trauma, and an interest in learning more about how to help those struggling with its effects, she found that a lot of this information and treatment was kept separate, reserved for the psychiatrist and/or psychologist. "I felt frustrated because I couldn't work through that whole piece with them, and I felt it was really important". It was this sense of frustration and helplessness that led Participant #3 to seek out more knowledge and experience working directly with trauma survivors later in her career. "I could not be a vehicle of being in a therapeutic alliance or anything like that if I was that frustrated. I knew the insight that I had, but I wasn't affecting any kind of change for them or anything like that if I stayed that way."

Participant #4 shared feelings of helplessness in relation to the barriers faced by her clients with concurrent mental health and substance use issues, the latter of which she recognized is "often rooted in trauma". She described a feeling of inability to "affect change" in the midst of rampant alcohol and drug use as well as homelessness, and commented, "it's such an intertwined thing with what I deal with, you know that homeless population and the concurrent disorders population…if we could solve the trauma problem, I'm not sure we would have the drug problem". These challenges and the ongoing exposure to homelessness and drug use amongst the client population she works with have admittedly led her to feel less empathy for her clients, and have resulted in her decision to leave her position (discussed later).

Participant #5 identified feelings of frustration when working with traumatized clients early in her career, when she lacked the awareness of their maladaptive behaviours as being an

expression or acting out in response to past trauma. “I would get more frustrated with people more readily, for really just acting like traumatized people”. As she began to gain more knowledge about trauma as her career progressed, participant #5 found herself feeling less frustrated by her clients, seeing their behaviour as a “sign or symptom of trauma” and taking a more supportive stance in her reaction as a result. She further described feeling frustrated by the manner in which mental health systems approach individuals with trauma, for example the provision of behavioural care plans that don’t consider the root cause of the behaviour(s).

Finally, Participant #6 relayed her frustration over the lack of resources available to her clients impacted by trauma. She spoke of long waitlists for counseling services and noted “sometimes it is the people who do have this long history of trauma that fall through the cracks and that do kind of like expose the lack of service”.

Transfer of emotional pain.

All six participants identified some aspect of emotional response to clients’ trauma material, which typically varied in intensity depending on factors such as the severity or level of detail of the trauma, and/or a personal connection or potential for countertransference reaction. These emotional reactions tended to occur at the time of the actual disclosure of trauma in the context of a therapeutic interaction with a client, or shortly following that disclosure. Participant #1 described this as “heart strings being pulled” and said she cried with clients at times because of how “horrific” some of the stories she has heard were. She described how on one hand it was difficult to remain composed, yet she also thought expressing her emotional reaction could serve as a therapeutic tool.

> You know I’m not a robot, so I felt it was important to be emotional with the patients so they understood that I understood their pain…they personalize a lot of it, and so that’s why I felt it was important for me to be vulnerable as well when I was listening to them.

Participant #2 described that when a client has shared a recollection of trauma with her she has first notices an emotional reaction described as a "gut feeling…almost achy feeling. You can call it emotional pain". This pain was associated with the pain of the client, and as a witness to that pain she felt she was watching them "reliving the trauma right before your eyes". She made a point of saying that the experience of hearing clients' did not cause her to feel traumatized herself, yet she acknowledged that, "regardless when it happened it is still very painful obviously to the person. And so at the same time, you are sharing this experience. So if I needed to label it it's kind of shared emotional experience…it's very uncomfortable and very painful". She also described a feeling of shock that she has experienced during some particularly gruesome abuse disclosures, in particular when a client seems to have normalized their experience or talk about it in a matter of fact way.

Participant #3 also described feeling emotionally "moved" by certain interactions with clients during which they shared the details of their trauma, for example an interaction with a survivor of residential school during which the client spoke in great detail about her abuse.

Participant #4 described a range of emotions in response to trauma disclosures, and described these as situationally dependent, but also related to her own personal experiences. She noted that her emotional responses varied from no reaction, to a "visceral" reaction, and noted that something that would evoke a countertransference reaction within her would be more likely to trigger an emotional response, for example stories involving childhood abuse.

> I'd sometimes rather not know those things. I mean not from like a clinical perspective- of course it's important. But I find that you know, that's the kind of stuff I take home with me. It's when I hear about the sort of horrible things that happen to children, you know the awful stories of assault and abuse and neglect and that kind of stuff; I find hard.

She also acknowledged at times feeling "annoyed" with clients who tended to dwell on or repeat trauma related experiences or stories.

Participant #5 shared that despite having been exposed to traumatic material frequently throughout her career, she never truly felt prepared for disclosures of trauma, and the emotional reaction that might ensue. She discussed the experience of a transfer of emotion or pain from the client onto herself, and acknowledges the potential for this to be triggering emotionally. Like Participant #1, she has cried with clients during disclosures. In addition to her emotional responses, Participant #5 described an internal thought process whereby she second guesses the appropriateness of her reaction to the disclosure, and also being mindful of the need to monitor her own emotional reaction or trigger at a later time.

Participant #6 also described an emotional response to some disclosures or sharing of trauma material by her clients. Similar to Participant #4, she identified having some incidences of a physical reaction, described as gagging feeling, which she was able to experience internally without revealing it to her client. She described this as "empathetic response" to feeling "so disturbed for them", and wanted to "take it away for them or something". She further identified feelings of anger towards the perpetrators of abuse or other trauma inflicted upon her clients when these details were revealed.

Difficulty leaving trauma at work.

All six participants reported having some difficulty disconnecting from traumatic material or experiences of their clients when away from work, often framed as "taking it home". Participant #1 identified this as highly problematic, contributing to her own diagnosis of PTSD. She described that it was common for her to think about her clients' traumatic experiences when

she was not working, that listening to the stories of patients "would put images in my head of the abuse" that resulted in intrusive thoughts and nightmares.

Participant #2 acknowledged difficulty leaving behind the emotions or thoughts about clients' trauma. "Obviously every time you have this profound conversation it stays with you". In contrast to Participant #1, however she framed the "taking home" as serving an adaptive function, whereby this allows her to consciously reflect on the client's experience and her reaction to it. "Well taking it home, and I know officially we are not supposed to do it, but we do, at least I do. Not all the time, but many times. And I do it because I need to process it".

Participant #3 spoke about "carrying around" clients' trauma material, at times having difficulty "letting it go".

> Especially in the beginning it was difficult not to take that on myself or not to carry that around. I always feel like there's this, it's almost like a little veil that I have, and when I take what's on for them and I can't let that go, I don't see through it very well. It's almost like a white fog that I'll see through.

She described being better able to manage this "carrying around of clients' trauma" as she gained more experience in her career, noting it has become easier to "let that go". She also acknowledged that in addition to taking home the actual traumatic material of her clients she also felt weighted down by the manner in which her clients were being treated by other healthcare providers, something also discussed by Participant #1.

Participant #4 admitted having some preoccupation with the traumatic stories of her clients, although said this occurred rarely and mainly in extreme cases or when she feels a personal connection to the content, for example stories of childhood abuse or neglect that would trigger a reaction due to being a mother herself.

> I mean I honestly don't think it affects me extremely, but you know there's stuff I will think about after work, like it'll come back to me. The story will come back to me and I'll think about it outside of work. I try not to really bring work home or think about work outside of work, so I know it's something that's affecting me if it's something that I think about later…I don't perseverate about it, but it'll be something that just sort of comes back to me, or I'll personally feel sad about somebody else's story when it's not mine to own.

Participant #5 described both short-term preoccupation and longer lasting impacts when discussing the "taking home" of traumatic material. Similar to Participant #2, she described a conscious, reflective process whereby she recognizes when she is triggered by or is carrying traumatic content and actively takes steps to process this. She also described a growing awareness of the less obvious, more insidious and cumulative effects of secondary trauma exposure, and commented that it would "show up in weird ways" even when she thought she "was doing all the right things" to avoid taking home her work. She described one such instance, after interviewing several "sexual predators" in the context of her role in forensic psychiatry. Despite feeling she was coping appropriately and "really good about pushing it off at the end of the day" she found herself being "triggered" by a "benign interaction" between a father and daughter while in a store approximately eight months after. This resulted in significant anxiety symptoms characteristic of a panic attack. She experienced another episode of anxiety that required medication and treatment while working in a harm reduction position with individuals with trauma-related illness. She described, "my anxiety was starting to get insidiously beyond my control where I was starting to get paranoid, and catastrophic thinking. But I remember thinking that job is obviously insidiously traumatizing me".

Participant #6 described a gradual awareness of her own "taking home" of trauma while working in a community-based child and youth mental health team . "[T]hat was hard to decompress from at the weekends and stuff like that. I found like I was like 'oh I can't take a break from it at the weekend'; like I would be thinking about someone's story, cause it would just be so intense and so sad".

Functional changes.

For four of the six participants interviewed, the taking home or carrying of traumatic material resulted in some element of functional changes. The most commonly cited functional change was disturbed sleep, which was reported by participants 1, 3, 5 and 6, and included decreased sleep, dreams, and nightmares.

Addictive behaviours were also identified by three of these participants. Participant #1 said she started smoking, increased her alcohol use, and struggled to control her eating in relation to difficulty coping at work, and identified the exposure to trauma material as one of these work-related stressors. Participant #3 indicated she drank more than she was "supposed to" and also tended to over-exercise during times she was impacted by trauma exposure. Participant #5 noted cravings for alcohol and drugs as a means to cope with the effects of trauma exposure, however did not engage in these behaviours.

Participants #1 and #5 identified having been diagnosed with and treated for PTSD in the past, and both participants endorsed the perspective that their exposure to their clients' traumatic material was a contributing factor to the associated symptoms of PTSD. For example, Participant #5 identified sleep problems, catastrophic thinking, intrusive thoughts, suicidal thinking, and panic attacks. Participant #1 identified nightmares, paranoid thoughts, and reported a suicide attempt due to stress at work.

Other functional changes reported were taking a longer time to relax after work and a reduced timeframe for the effects of stress to take hold upon returning to work by Participant #6, and jaw clenching by Participant #3.

Effects on employment status.

The negative impacts of working with traumatized individuals were a key factor in the decision to leave a position and/or absenteeism for four participants in the study. Participant #1 took several short and long term disability leaves from work due to a combination of secondary trauma exposure and other work-related factors. At the time of the interview, she expressed plans to move into a different area of nursing, which she attributed at least in part to the impacts of being exposed to clients' trauma.

Participant #4 attributed a decision to move to a new position as in part influenced by her work with a highly traumatized population. She identified "getting annoyed when I shouldn't be" and losing some empathy towards her client population. The awareness of rampant drug use, violence and other trauma related to homelessness and the "ongoing exposure to it" influenced her decision to leave.

Participant #5 also identified trauma exposure as the sole factor in her decision to leave her position in a forensics environment, and as a significant factor in her decision to leave a position in harm reduction where she was working with individuals with trauma-related illnesses. She also acknowledges taking more sick time as a result of the negative impacts of exposure to trauma. She described this as an "avoidance" behaviour.

Finally, Participant #6 identified leaving a child and youth mental health team where her role included treating clients with significant childhood trauma, and cited the impact of trauma exposure as the primary reason for this decision. "I couldn't do it anymore…even with the extra training I just got so drained with it…I found it really, really hard…After a while I was able to

sort of recognize that I just wasn't able to offer my best in it, so then when I switched to this job, it was kind of a relief".

Positive Impacts of Working with Traumatized Clients

While all six participants in the study identified some element of negative impacts as a result of working with trauma survivors, the same participants all identified some positive experiences or changes within themselves as a result of this work; these benefits outweighed the negative impacts in some cases. All six participants identified negative impacts before positive impacts when asked about their experience working with traumatized individuals. Four of the six participants spontaneously talked about positive aspects of their experience, whereas two participants had to be prompted by the question, "can you identify positive impacts of your experience?". Sub-themes identified in the realm of positive impacts of working with traumatized clients were: enhanced awareness of the resilience of people, feeling rewarded by the work, improved personal relationships, and increased empathy and reduction in judgmental attitude.

Recognizing resiliency.

Five of the six participants expressed an enhanced appreciation for the resiliency of people as a result of their work with traumatized individuals. Participant #2 expressed that working with traumatized individuals has influenced not only her appreciation for their resiliency, but in turn has made her a more resilient, stronger person and contributed to her own "trauma growth".

> [N]egative experience is a great opportunity for some growth. I think I'm quite resilient. I know that my clients are extremely resilient because I don't know if I could be as normal as they are (laughs), knowing what they went through. But at the same time I think my

> own resilience in a sense probably also helps me to keep somebody else's trauma in perspective. I'm affected by it, but it cannot damage me. And I think I'm very clear with myself, you know, that it cannot injure me.

Similarly, Participant #5 spoke about recognizing clients as "experts" of their own experience and drawing on their resilience in her own practice, for example by utilizing these to promote the recovery of other clients. "I learn every day from the people who I work with, who teach me so much about resilience". She described that the recognition of the resilience of her clients has led to her own experience of "vicarious resilience". She described, "you're watching someone with trauma grow and develop and experience life with new light, and as such you learn their techniques and strategies and what worked for them, so that to me is vicarious resilience".

Participant #3 also expressed an enhanced appreciation for the resilience of people as a result of her work, becoming tearful when she shared this aspect of her experience.

> Many times I've come away with (I can't believe how it's touching me), with just how giving people were, and how willing they were to tell me about it. Just like, yeah, they could just walk out the door and face that world again, whether it was the street, whether it was the jail, or and they could walk right back into that, and they could still survive.

Participant #4 said that her work with traumatized clients has helped her to recognize people's resiliency and "ability to overcome", enhancing her perspective of her own life and the lives of others. Participant #6 also expressed how "impressively resilient" many of her clients have been.

Feeling rewarded.

Five participants mentioned a sense of reward or gratitude from the work they have done with traumatized clients, particularly in the context of seeing people get better and heal from trauma. Participant #1 identified this sense of reward and described a memory of one client thanking her for saving her life. Experiences such as these served to reinforce that she was doing "good work" with her patients.

Participant #3 described feeling grateful to clients who share their experience and story with her. "[T]hat humanness was there, that love, and that compassion, and that beauty of who they were in their spirit were still there, that wasn't gone…I was always so grateful for them for taking me there and allowing me to be there with them".

Participant #5 expressed a sense of reward stemming from feedback from clients about how she impacted their healing. She also expressed gratitude for being part of the recovery process of her clients.

> When you have a tangible sense of reward and appreciation within the work that you get to do and the opportunity that you get, it's huge…I feel honored to be a part of their growing experience…I'm so honored to be here. I'm so honored that they feel safe enough.

Participant #6 similarly described reward in being part of people's recovery.

> When you see people recovering; like something bad happens and they're able to get through it, and you're a little bit of a section of helping them get through that. That's really cool; that's really emotional to be part of that. And a lot of the times a lot of the work is the client doing it themselves, you just happen to get to witness it…A lot of people don't get to witness that in another person; it's kind of like a privilege to be part of that.

Improved personal relationships.

Five participants identified gains in their personal relationships as a result of their experience working with individuals who have experienced trauma. Participants #2 and #5 described how their experience translated into them being more understanding, tolerant and less judgmental in the context of their personal relationships.

Participant #3 discussed an enhanced focus on the quality of her relationships with family and friends as a form of self-care to protect her from the negative impacts of her work. She described an increased appreciation for her children, for example and made efforts to spend quality time with them. “I appreciated my kids more because I didn’t want them to have to suffer like a lot of the people that I had seen”.

Participant #4 identified a contrasting element of enhanced relationships as a result of working with traumatized individuals, this being “less tolerant” of people’s negative behaviours in her personal life. Less tolerance was framed in the context of having improved boundaries in relationships, for example she no longer wants to be around people who use drugs recreationally.

Finally, Participant #6 described having more awareness of the potential for trauma in all people. “Everybody has trauma; we all have something that triggers us”. She notices she is able to respond to those in her personal life less personally as a result of recognizing the potential for these trauma-related triggers, and feels her personal relationships have benefited as a result. “I think actually that’s generally really helpful in your relationships long term; I think that’ll keep solid relationships with people because you’re not allowing all the stuff to get in the way”.

Increased empathy and reduced judgment.

Most participants identified the experience of working with individuals with trauma histories as impacting the way they see others, both in personal and professional capacities. Specifically, participants spoke about have greater empathy for others, as well as a reduction in

judgments of others. For example, Participant #2 said the work has made her more "accepting and more understanding in general". She went on to describe how enhanced empathy for her clients who have been traumatized has altered her expectations of them in her nursing practice. "In the context of trauma then, it becomes at times inappropriate to expect that people have the ability to actually take full responsibility, even for their actions, because some parts are missing. And unless we actually rebuild those missing parts, maybe not 100%, it's just unrealistic expectations". She also endorsed feeling less judgmental of her colleagues and employees.

Participant #4 said she is more empathetic, and "a better person from having done this work". She acknowledges that her experience and growing appreciation for the impacts of trauma have made her "a better nurse", for example she is mindful of the potential for re-traumatization and takes a more gentle approach with her clients as a result.

Participant #5 similarly reflected on how working with traumatized individuals and learning to understand their behaviors through a trauma informed lens has resulted in her being much less judgmental of their behavior.

> We all judge because we're humans and we have biases and assumptions, but I've found that I get feedback from people all the time – friends, family, clients, about I just made them feel like human, or non-judgmental… I'm constantly working on that, and probably will until the day I die, but it's really cool to hear that you've made someone feel not judged or you've allowed someone to feel not judged. Cause that's ultimately what we want to do.

Participant #5 also noted that her awareness of the potential for vicarious trauma amongst colleagues and service partners has translated into her taking a less judgmental stance in response to their behaviours.

Similar to Participant #5, participant #6 identified an enhanced way of being with her clients as a result of her experience working with traumatized individuals, such that she recognizes their responses are a reaction to trauma and doesn't personalize or judge their behavior.

> I think over the years I've gotten really good at noticing, like being able to totally detach from that being about me, and just holding that for them and be for them in that space and allow them to like get angry or vent, and then being able to go back and talk to them about that later. I think that's been really helpful for my clients.

Protective Factors

All six participants described conscious, deliberate, and specific strategies they have used to mitigate the negative impacts of working with traumatized individuals. These were focused around self-care and seeking support.

Self-care.

All participants endorsed the need to pay close attention to their personal well-being in order to counteract the effects of working with traumatized individuals, and identified practices that alleviate these impacts with at least some success. For all participants these practices were identified as necessary to maintain on an ongoing basis to facilitate overall wellness and buffer against the strains of their work. Self-care practices may also be increased during times of particular stress.

Participant #1 identified getting a dog, and finds it helpful to be outside taking walks. She also finds it helpful to watch movies and spend time with her son. Participant #2 talked about conscious personal reflection and processing of triggering trauma material as essential to maintaining her own health and preventing secondary traumatic effects. Participant #3 said she did "a lot of self-care", such as taking hot baths, walks on the beach, holidays, and spending

more quality time with family and friends. She also noted that volunteering and giving back to her community are essential to her wellness. Participant #4 identified having work/life balance as essential for coping, and participates in yoga and cycling on a regular basis. Participant #5 spoke about an awareness of the need to "take care of herself" after graphic disclosures of trauma, and identified practicing self-forgiveness and self-compassion "for making mistakes or being worn down" as important. Finally, Participant #6 identified being out in nature, exercise and engaging in hobbies as helpful. She also found it important to avoid shows or movies containing sexual violence or other types of violence or that are stress-inducing.

Seeking support.

Five participants identified seeking out support from others to assist them to cope with the negative effects of working with traumatized clients. For four participants this included formal treatment by a physician or counseling, and two of these participants have been prescribed medication to assist them in coping with these impacts. Participant #1 found medication helpful for the sleep and anxiety symptoms associated in part with the exposure to clients' trauma material. She also attended counseling, however did not find this helpful. Participant #3 shared that at various points in her career she utilized counseling through her Employee and Family Assistance Program (EFAP), and saw a psychiatrist to assist her to deal with the effects of secondary trauma exposure. Participant #5 also attended formal counseling with a therapist trained in trauma work.

> I go to a therapist that is trauma trained. She does EMDR, she does prolonged exposure therapy, she does hypnotherapy, all of the things that are trauma based. Because even though I'm insightful and I can do talk therapy, I don't know what is sitting in all of my cells, and sitting in the neurochemistry of my brain. And so I need to do trauma therapy

> with an expert in trauma therapy so that it's not sitting in my body somewhere and causing other issues.

Participant #6 also went to counseling on a couple of occasions to help her to cope with the impacts of working with traumatized clients.

In addition to formal mental health treatment or support, participants also identified seeking support from colleagues in the form of team dialogue and/or debriefing as a significant protective factor to reduce the effects of exposure to clients' trauma. Participants 3, 4, 5, and 6 in particular found this aspect of seeking support crucial. Participant #3 recalls reaching out to one of the social workers she worked with immediately following an upsetting event with a client that personally triggered her and was able to "work through" this with this colleague's support. Participant #4 has utilized debriefing services with her team and found this very helpful to reduce the impacts of secondary trauma. She also cited the "team energy and the team dynamic and the support of the team" as essential to her well-being. She has further felt it important to seek support from peer coordinators and her own manager and has found this helpful. Participant #5 described seeking out like-minded colleagues as particularly important.

> I like to find people who have similar mindsets. Because the last thing I want to do is hear someone say, 'well you spend too much time with them'. Or 'you shouldn't have opened that up'. So I don't want blame or shame. I just want someone to listen or laugh and being a human with me.

Participant #6 discussed how team support and debriefing has a significant role in allowing her to continue to do the work she does.

> They're definitely the main reason that I'd still be a nurse today; having skilled colleagues that you can go to or just other people that normalize your experience, or just other nurses that are willing to listen, or other nurses that have good practical ideas.

She spoke about having had the opportunity to seek guidance about disclosures of trauma in a group setting, and found this particularly empowering.

Shifts in Philosophy of Practice

In the context of talking about their experience of working with individuals with trauma or answering the interview question, "What has helped you cope with these effects?", a significant theme emerged whereby participants identified a shift in their philosophy of psychiatric nursing practice as essential to allowing them to cope with or benefit from their work with traumatized individuals. Education, training, and experience were cited as the agents in this shift. Most participants talked about a gradual awareness of the prevalence of trauma and its clinical significance as they gained experience in the field, as opposed to entering practice with this knowledge. They further noted they had consciously sought out new knowledge, training, or experience in the areas of trauma and trauma informed practice. Most also discussed experiencing fewer negative effects once they embraced a different (more trauma-informed) philosophy. For example, Participant #2 spoke extensively about how a conscious shift towards being "trauma informed" has been the most significant factor for her in terms of mitigating the potentially negative consequences of working with traumatized individuals.

> I think you really have to learn about the nature of trauma…just reading and self-study and just understanding what's happening even from a physiological point of view, it really helps. I think I became much more accepting of some of the reactions, and it's like well yeah, this is what happens, we are not robots.

In addition to strengthening knowledge, Participant #2 discussed the importance of integrating a trauma-informed philosophy into one's way of being and seeing the work. "So having an understanding, it needs to be internalized into who you are and your value system" in order for it to be impactful.

Participant #3 described feeling unsatisfied with her level of knowledge about trauma as an RPN in her early career, and actively engaged with other professionals such as psychiatrists and psychologists in order to increase her knowledge, and contribute more actively to trauma treatment. She recalled that initially her lack of knowledge of trauma and this aspect of care was seen as beyond her role or scope as a psychiatric nurse which was limiting to her practice, "and to some degree in the beginning it interfered with how I was able to interact with my clients". She sought out additional education such as conferences with Gabor Maté and dialectical behavior therapy (DBT), and also completed a Masters degree with a focus on Indigenous residential school experience. She endorsed that her additional education and training in working with trauma survivors made her a more effective and fulfilled psychiatric nurse and that she became passionate about working with the "trauma piece".

Participant #4 also expressed feeling underprepared to work with trauma in her early career, and notes that as a coordinator she continues to observe psychiatric nurses and students as lacking sufficient knowledge in trauma informed practice, particularly in regards to vicarious trauma. She also identified that knowledge she has gained through her Masters' studies and other avenues of education she has sought out, have enhanced her practice, for example causing her to be more "gentle" in her approach. She also endorsed that additional training has been helpful in terms of minimizing negative consequences of working with traumatized populations.

Participant #5 discussed a dramatic shift in her philosophy of practice as a result of learning more about trauma, how it influences people's behaviour, and TIP. She spoke about how greater awareness of trauma and its impacts has led her towards more compassion and understanding of people's experiences in our healthcare systems, shifting away from judging their behaviour and focusing more on maladaptive behavior as a trauma response. When discussing this shift in philosophy she stated,

> [p]rofessionally, that made all the difference…When you become trauma informed too, instead of listening so that you can give advice, or listening to treat, you're listening so that you can learn about the person, because they're the expert, and so you just want to support them in a journey, whatever that sounds like.

Participant #5 also discussed how seeing her clients through a TIP lens allowed her to gain compassion for herself and her experience in caring for individuals with trauma, such that she became gentler with herself, and experienced far fewer negative effects from working with trauma survivors.

Participant #6 also acknowledged a lack of preparedness and education about "what to do" when clients disclosed trauma details early in her career. "Our role was much more managing the behaviors". As a result of taking a position working with a highly traumatized population, she had the opportunity to take specialized training in working with trauma survivors, and found this extremely beneficial in terms of her confidence and competence. "It really helped having some formal training" such as trauma focused CBT. "It was a tangible thing I could do". She particularly found it useful to provide psychoeducation to clients regarding traumatic responses, being able to normalize their experiences. Similar to Participant #4, Participant #6 also expressed her "way of being with clients" has shifted as a result of more experience and education in trauma and TIP. Earlier in her career she felt more "reactive", or tended to take more personally an individual's behaviour, and is now more able to "hold space" for clients while recognizing the root of the behaviour. "I definitely don't get as upset in those moments". This has occurred over time as a result of gaining experience and additional training in trauma, TIP, and trauma interventions.

Lack of Organizational Supports

Five participants in the study expressed that there is a need to improve supports for psychiatric nurses in order to mitigate the negative effects of working with trauma survivors. This was not discussed in participant #2's interview given her leadership position within her organization. Additional educational opportunities related to trauma or TIP and more formal debriefing opportunities were most frequently cited as recommendations to organizations. For example, Participant #1 expressed that there is not enough education within her health authority for nurses. "I think there should be more education days, because it pulls people together, and we realize I think everybody is struggling. I think it bonds the nurses, it gives us skills, and it gives us a day off work to recuperate".

Participant #3 identified a need to improve supports for psychiatric nurses in order to mitigate the negative effects of working with trauma survivors, arguing that these supports need to be put in place during RPN training, as well as on an ongoing basis by employers. Workplace culture and supports were viewed by this participant as essential to honoring nurses' experiences, whereby "[i]t needs to be "okay" to be affected, to be human in these situations". In the workplace,

> [d]ebriefing and resolution need to become a natural part of the work process verses an exceptional or a post-traumatic stress event. We need to adopt language that honors a nurse's experience that is specific for nurses and not pathologized or diagnosed as a "disorder"…we need a debriefing team that is readily available to support and help nurses every day. If it becomes a natural extension of our work, like meal breaks, then it is more acceptable for nurses to deal with and survive better in the work place.

Similarly, Participant #5 expressed that "health authorities have fallen short significantly in fostering a safe conversation, or even a place where we can have conversations about getting

support". She describes stigma attached to asking for help within these organizational structures, and has been discouraged by colleagues from admitting the need for help. In the majority of healthcare settings she has worked in "there wasn't any conversation about it", i.e. the effects of working with traumatized clients.

Participant #4 reported that the TIP training offered by her health authority is insufficient for those (including psychiatric nurses) who work in mental health and substance use practice areas. "Better education would be helpful…It's all sort of the stuff we already know, and it would be helpful if it was a bit more in-depth, and more about how vicarious trauma stress and secondary trauma stress can affect the frontline workers".

Participant #6 also feels employers could reduce the impacts faced by psychiatric nurses by providing more acknowledgment, discussion, and formal education pertaining to the impacts of secondary trauma on healthcare professionals. She noted she has had to seek out her own knowledge, rather than being offered it by her employer, and expressed that the current TIP training offered in her health authority is insufficient. "[A] lot of the people that I work with on this team, the psychiatric nurses haven't really had the chance to do much trauma training or how to look after themselves".

Chapter 5: Discussion of Findings

The over-arching goal of this research was to address a significant gap in the literature pertaining to the impacts of secondary trauma exposure in psychiatric nurses, with a more specific goal of understanding the meaning of their lived experiences. Thematic analysis, using Crist and Tanner's (2003) framework for hermeneutic phenomenological interpretation, resulted in identification of seven central themes that have significance in terms of their placement within the scope of the current literature, as well as their implications for psychiatric nurses, psychiatric nursing educators, and employers.

Alignment with Current Literature

As discussed in Chapter 2, there is a scarcity of existing literature that addresses the experience of psychiatric nurses who work with traumatized individuals, especially within Canada. When compared to established results among other mental health professionals, Robinson et al. (2003) found similar rates of VT, higher than average rates of emotional exhaustion, and yet significantly higher rates of personal accomplishment in their sample of RPNs in Manitoba. These seemingly contradictory results are consistent with the current study's findings that both positive and negative consequences of trauma work occur in RPNs.

The Registered Psychiatric Nurses Association of Saskatchewan (RPNAS) (n.d) carried out an important study to identify variables influencing PTSD and depression in psychiatric nurses in that province. However, while vicarious trauma exposure was identified in their discussion as a possible factor of relevance, it was not examined or measured specifically. The authors did conclude that research of a qualitative nature with psychiatric nurses would supplement their findings and should inform solutions (RPNAS, n.d).

Using a population of advanced practice psychiatric nurses in the United States, Beeber et al. (2017) provided evidence that validated the existence of five key components of the concept

of secondary traumatization, although acknowledged their study is methodologically challenged (Beeber et al., 2017). Mangoulia et al. (2005) provided data to inform prevalence of secondary traumatic stress, compassion fatigue, burnout and compassion satisfaction among psychiatric nurses in Greece, although they were not specifically focused on secondary trauma exposure as contributing exclusively to these outcomes. Tirgari et al. (2019) similarly presented findings regarding the correlation between PTSD and ProQOL among psychiatric nurses and rates of PTSD, burnout, compassion satisfaction, and compassion fatigue among their sample, however their study did not focus on secondary trauma exposure as the source of these outcomes.

Given the limited literature available that focuses on the experience of psychiatric nurses, the current study's findings may be best analyzed by utilizing additional research from other nursing specialties and disciplines outside of nursing.

Negative impacts of trauma work.

The finding that 100% of the psychiatric nurses interviewed in the current study reported some negative impact, even if those impacts were fleeting, is well-aligned with findings from researchers studying other disciplines or nursing specialties that engage with clients' trauma material. For example, in Arnold et al.'s (2005) qualitative study exploring the experience of psychotherapists working with trauma survivors, 100% of participants also reported negative effects. Buchanan and Walsh (2011) reported all five of the acute care nurses interviewed regarding their experience of witnessing the trauma and suffering of their patients identified situations that they carried with them, sometimes for years following the event (p. 357). This is consistent with the current researcher's finding that 100% of the sample reported taking trauma material home with them.

In terms of specific symptoms or consequences of secondary trauma exposure, findings from the current study are again consistent with those reported in the literature. Walsh and

Buchanan's (2011) findings included a qualitative theme of nurses taking trauma material home, in much the same manner that the current study's participants discussed. The nurses in their study also reported feelings of frustration, and helplessness, which were prevalent among the current study's participants. In Arnold et al's. (2005) study, participants reported intrusive thoughts, images, and/or dreams about clients' traumatic material, for example, which participants described as brief in duration (a few days) and occurring less frequently as they gained more experience in their career. Researchers examining secondary traumatic stress in emergency department nurses also reported intrusive thoughts about patients as the most common intrusion symptom among their sample, and found 50% of their sample experienced disrupted sleep (Dominquez-Gomez & Rutledge, 2009). Additionally, 21% of Robinson et al.'s (2003) participants who worked with trauma survivors also reported persistent thoughts about clients' trauma material identified as intrusive images, distressing dreams or feelings of distress triggered by reminders of these events. Disruptive and recurrent memories were also identified as a significant theme in a qualitative research study using emergency nurses (ENs) working with survivors of intimate partner violence (IPV) (van der Wath, van Wyk & Janse van Rensburg, 2013). Intrusive thoughts about patients and sleep disturbance were also among the five most common symptoms in a sample of oncology nurses (Quinal, Harford, & Rutledge, 2009). In the current study, all six participants reported some level of preoccupation with clients' trauma material, varying in degree from occasional to frequent and from adaptive to significantly disruptive. In addition, 80% of these participants reported sleep disturbances including nightmares. Half of the participants acknowledged feeling less preoccupied with clients' trauma material and better equipped to manage it as they gained more experience in their careers, consistent with Arnold et al.'s (2005) finding.

The transfer of difficult emotions from clients onto the psychiatric nurse was another commonly reported phenomenon in the current study that has been previously demonstrated by researchers (Arnold et al., 2005; Maytum, Heiman & Garwick, 2004; van der Wath et al., 2013; Walsh & Buchanan, 2011).

> When observing the physical injuries and emotional pain caused by IPV and listening to the narratives of how the violence occurred, ENs experience distressing emotions, which are sometimes similar to what the survivor is feeling… Witnessing the survivors' suffering has an emotional impact, leading to feelings of depression, sadness, fear, shock, sympathy and anger (van der Wath et al., 2013, p. 2245-6).

These emotional consequences were echoed by Walsh & Buchanan (2011), who identified shock and difficult emotions caused by ongoing exposure to patients' trauma and suffering as significant themes. Half of the participants in the current study also identified feeling shocked or underprepared when exposed to their clients' trauma material. Feelings of sadness and wanting to take away the pain of the client were also reported by most participants in the current study, and anger towards the perpetrator was also described by one participant.

Reduced empathy and self-doubt about their ability to help clients is another finding evident in both the current study and Buchanan and Walsh's (2011) study of acute care nurses. They reported that all participants experienced "shifts in their ability to be compassionate in times of duress" identifying themes that described their "struggle to maintain/achieve a sense of accomplishment, as well as concern for the lack of resources within the work context and how that subsequently affects their level of performance as acute care nurses" (p. 357). In van der Wath et al.'s study (2013) emotional detachment was also identified as a way to avoid the pain associated with a "sympathetic attitude" (p. 2246).

Changes in relationships, which emerged as a theme in the current research, has been cited in the current literature exploring the impacts of working with trauma survivors, however has not been an area of significant focus. Relational distancing specifically has been identified as a symptom of CF (Sinclair et al., 2017). Distancing was identified as a theme in Walsh and Buchanan's (2011) qualitative study using a sample of acute care nurses. "All of them spoke of distancing themselves at work, and the majority of participants also spoke about isolating and distancing themselves at home with their families. They stated that this was the only way to cope with their feelings; however, they were also clear that they did not like using this coping strategy" (p. 358). Social detachment is similarly identified as an avoidance symptom in both PTSD and secondary traumatic stress disorder (Gates & Gillespie, 2008).

Increased use or craving of substances was identified in 50% of the current study's participants, however has not emerged as a significant finding or theme in the literature on impacts associated with secondary trauma exposure. Nevertheless, Jarrad, Shawashi, and Mahmoud (2018) identified compassion fatigue as a risk factor for substance use among nurses, and according to Ross, Berry, Smye and Goldner (2018), who conducted a critical review on the subject matter, other authors have identified workplace stressors and burnout as contributing to substance abuse among nurses. Todaro-Franceschi (2013) also included substance abuse as a symptom of CF, and Australian researchers studying substance use among nurses found the "sometimes-traumatic nature of nursing" to be a significant contributing factor for their substance use (Lillibridge, Cox & Cross, 2002, p. 223). Using a population of social work students volunteering following Hurricanes Katrina and Rita, Prost, Lemieux and Ali (2016) noted that post-traumatic stress symptoms among this sample was positively correlated with use of alcohol and other drugs as a coping mechanism. No studies could be found that explored substance use among nurses in response to vicarious trauma specifically.

Limited research exists that examines the negative consequences of secondary trauma exposure as a direct cause of psychiatric nurses being absent from work or leaving their position, which was relevant to five (83%) of the current study's participants. There is, however ample literature that identifies burnout and compassion fatigue as contributing to these problems among nurses (Mealer & Jones, 2013; Sheppard, 2015; Sorenson et al., 2017; Todaro-Franceschi, 2013; Yoder, 2010). Yoder's (2010) sample of nurses reported decreasing their work hours, transferring units, leaving an organization, and leaving nursing altogether in reaction to CF. Todaro-Franceschi (2013) identified avoidance of work, absence from work, and chronic lateness as signs of CF. Sheppard (2015) identified low morale, impaired job performance, absenteeism, and turnover among nurses as consequences of CF. Mealer and Jones (2013), in their concept analysis of PTSD in nurses, framed these as avoidance reactions to secondary trauma exposure, stating that "[a]voidance is manifested in nurses through increased absenteeism and avoiding taking care of specific patients that remind them of a traumatic patient encounter" (p. 284).

Positive impacts of trauma work.

The current study provides evidence of the potential for reward and personal and/or professional growth among psychiatric nurses who work with individuals with trauma, given that 100% of the sample reported some positive outcomes as a result of this experience. This finding was also reported by Arnold et al. (2005), who acknowledged that the bulk of the existing literature has focused on negative impacts of trauma work such as STS and VT, even if positive outcomes were mentioned as a possibility. "Without exception, however, these positive consequences have been mentioned somewhat tangentially, in the context of more comprehensive explorations of the negative sequelae of trauma work" (Arnold et al., 2005, p. 243). While earlier literature has not focused heavily on these positive outcomes, the idea that

positive outcomes can be experienced is increasingly supported by researchers that examine the experience of working with trauma survivors. Calhoun and Tedeschi (1999), who coined the term vicarious post-traumatic growth (VPTG) have described this as a similar outcome experienced by trauma survivors themselves, and identified VPTG as occurring in three main areas: positive changes in self-perception, interpersonal relationships, and philosophy of life. Other findings have included "important work-related benefits or rewards including gains in relationship skills, increased appreciation for the resilience of people, satisfaction from observing growth, and being part of the healing process" (Barrington & Shakespeare-Finch, 2013, p. 91). Increased sensitivity, compassion, insight, empathy, tolerance, and improved interpersonal relationships were also reported by Arnold et al. (2005). In van der Wath et al.'s (2013) study, the authors reported findings that emergency room nurses working with survivors of IPV feel a sense of relief when survivors are offered help, and this was identified as a way to assist them in coping with the initial negative emotional impact of their vicarious trauma exposure. Parallels can be drawn between these positive aspects of trauma work and those reported in the current study in areas recognizing resiliency, feeling rewarded, improved personal relationships, increased empathy, and reduced judgment.

Relevance of personal trauma.

Personal trauma, while not a focus of the current study, was spontaneously discussed by participants, who often felt it was relevant to their experience of working with traumatized individuals in some manner. Interestingly, some researchers have identified personal trauma history as a risk factor for negative consequences such as VT (Figley, 1995; Pearlman & Saakvitne, 1995), however others have not supported this variable as significant (Dunkley & Whelan, 2006; Schauben & Frazier, 1995). In their study using a population of emergency room nurses in South Africa, van der Wath et al. (2013) reported that one participant

spontaneously related her experience working with survivors of IPV to her own earlier trauma, and noted her concern for patients sometimes became interrelated with that experience.

While a relationship between personal trauma in healthcare professionals and later development of VT or STS has been discussed, the current literature has not explored this relationship in significant depth. Some authors have proposed that lack of closure or healing of personal trauma may be of particular importance as a risk factor in the negative response to secondary trauma exposure or CF (Figley, 1995). "If the nurse had not coped effectively with his or her past trauma experiences, current and future exposures to traumatized patients may remind the nurse of the past trauma and consequently increase the likelihood of STSD" (Gates & Gillespie, 2008, p. 245). With respect to the current study's findings, participants displayed a high level of insight into how their own trauma influenced their experience of working with traumatized individuals. In some cases past trauma served as a trigger when working with clients experiencing similar types of trauma, however these RPNs articulated that they were able to recognize, acknowledge, and process these trigger responses effectively. Most also framed their own traumatic experiences as a source of value, allowing them to have greater empathy for their traumatized clients. This finding was also evident in Arnold et al.'s (2005) study of psychotherapists, wherein 100% of the clinicians that reported personal trauma said their own trauma had led to growth in areas of resilience, independence, sensitivity, compassion, and spirituality.

Protective factors.

In the current study, participants identified purposeful attempts to prevent or minimize the negative effects of exposure to clients' trauma material. Themes centered on self-care and seeking of support from others, including colleagues and professional supports. While these areas of coping have been widely cited as recommendations in literature pertaining to VT, CF,

STS, and burnout, they have not been tested empirically (Bercier & Maynard, 2015), and further research is needed that identifies practices that may prevent or reduce the negative effects of secondary trauma exposure (Harrison & Westwood, 2009).

> When individuals trained in the helping professions abandon the field, because of a perceived burden of caring and an insufficient ability to balance work with other aspects of life, this constitutes an enormous loss of resources and potential. When clinicians continue working, despite suffering from the damaging effects of VT, this constitutes a tremendous disservice to both clients and therapist, and the health of our community is undermined. It is imperative to address these concerns on ethical grounds, as clinicians and researchers alike must strive to provide appropriate, effective care for traumatized clients as well as those who work with them (Harrison & Westwood, 2009, p. 204).

Self-care as a protective factor has been cited abundantly in the literature. Newall and MacNeil (2010) defined professional self-care as "the utilization of skills and strategies by workers to maintain their own personal, familial, emotional, and spiritual needs while attending to the needs and demands of their clients" (p. 62). Maytum, Heiman and Garwick (2004) identified personal coping strategies as significant to a sample of nurses working with children with chronic health conditions and their families, and reported common self-care strategies used by their participants including exercise, meditation, journaling, spending time with loved ones, and engaging in fun activities. Researchers have demonstrated that alterations in behavior such as spending time with loved ones and spiritual practices can positively influence the development of VPTG (Shakespeare-Finch & Barrington, 2012). Mangoiline et al. (2005) also highlighted the importance of self-care to reduce the experience of CF. "Taking time to sustain relationships and practice self-care results in less CF. When we care for ourselves, we can care for others from a place of abundance not scarcity. With development of healthy self-care

routines, nurses can continue to successfully provide compassionate care to others" (Mangoulia et al., 2005, p. 334).

In addition to self-care practices, RPNs in the current study identified the need to seek support from others including colleagues, and in some cases professional support such as counseling. This finding is consistent with literature that addresses the needs of individuals working with trauma survivors. Mangoulia et al. (2015) identify personal, professional and organizational supports as potential protective factors against STS. In Robinson et al.'s (2003) study, access to peer support was correlated with lower levels of VT among RPN participants, and positive relationships with co-workers was cited as a contributing factor to a sense of increased personal accomplishment. Yoder's (2010) sample of nurses identified informal debriefing with colleagues including other nurses, managers, and physicians as useful coping strategies. McCann and Pearlman (1990) identified formal support in the workplace as necessary to protect against VT, suggesting weekly case conferences and other group/collaborative opportunities for individuals working with traumatized individuals. Newall and MacNeil (2010) identified sources of social support from professional colleagues including "concrete support, such as assisting with excess clerical work or taking on a particularly difficult client, or emotional support, such as comfort, insight, comparative feedback, personal feedback, and humor (p. 62). Harrison and Westwood (2009) identified social support as one of nine prominent themes in their research with mental health therapists exploring protective factors for VT. "All participants value the role played by their personal community of family and/or friends in helping them to maintain balance and separate work from the rest of their life" (Harrison & Westwood, 2009, p. 208). The same participants also discussed the importance of formal support such as personal therapy for those working with trauma survivors, and some participants spoke about the benefit of group therapy in particular. Taking care of one's own mental health was

framed by participants as an "ethical responsibility", whereby "[i]f they do not take care of themselves, they are at risk of harming others" (Harrison & Westwood, 2009, p. 211).

Shifts in philosophy of practice.

The current study's participants discussed feeling unprepared to work with traumatized individuals at the outset of their careers, thereby having to consciously educate themselves about trauma and how it may influence the behaviors of their clients and their own reaction to those behaviors. A substantial theme emerged in the interviews whereby conscious reflection of their own nursing philosophy or work with trauma survivors served to minimize the negative effects of vicarious trauma exposure, which was fundamental to their sense of professional efficacy and personal well-being. For the majority of these participants, this included adopting a trauma informed philosophy. Despite the significance of this adaptive shift in philosophy reported by psychiatric nurses in the current study, and the expanding research on TIP, there is limited research that has explored the influence of an individual's practice philosophy (including TIP) on VT. Maytum et al. (2004) however, reported the finding that "participants identified the need to be philosophically "on board" with their work and to have personal beliefs that gave them strength" (p. 177). Harrison and Westwood (2009) discussed the relevance of creating meaning to reduce the impacts of secondary trauma exposure that became evident in their qualitative interviews with mental health therapists. "[T]hese therapists recognize the importance of their ability to create or perceive meaning, regardless whether through belief in an ultimate universal goodness, an elusive transcendent greater purpose, their commitment to family, work, and/or community building, or a sense of interconnection with the efforts of others in continuity over time" (Harrison & Westwood, 2009, p. 213). While this theme may center more on the personal philosophy of mental health therapists as relevant to their wellness, it is the process of meaning making that can allow clinicians to "contextualize and reduce the threat of trauma" (Harrison &

Westwood, 2009, p. 213). Harrison and Westwood (2009) also found that mental health professionals may benefit from examining and accepting their relationship to the trauma of their clients, and work to integrate this relationship and experience into their identity, rather than avoid engagement with clients' traumatic material as a means to protect themselves, which may be counterproductive (p. 214).

Pack (2014), in her study of the vicarious resilience (VR) among sexual assault therapists also suggested that a reflective process is necessary to allow clinicians to move from VT to VR, stating that "[t]hese cycles of personal reflection and development of the relationship between self and other, client and self, and spirituality…are connected processes in which the trauma therapist is engaged. These processes, over time, enable therapists to make sense of their work, themselves, and the societal forces that color the environment in which sexual abuse and therapy take place" (p. 19). Pack (2014) also discussed shifts in theoretical frameworks and philosophies as paramount to developing VR among her sample. Pack (2014) maintained that "[t]he counselor participants moved beyond traumatization to enact their personal and professional values and philosophies as a way of dealing with the experience of dissonance, which is the hallmark of vicarious traumatization. Out of such experiences, there is a search for meaning and the movement from one theoretical framework to a bricolage of many; from a rule-bound to a process- orientated context" (p. 28). She further commented on the dissonance that can occur in therapists when their philosophy of practice is misaligned with that of their employer or organization.

Mealer and Jones (2013), in their concept analysis of PTSD in nurses, proposed the application of the 'Nurse as Wounded Healer' theory (Conti-O'Hare, 2002) to explain nurses experience of and adaptation to both primary and secondary trauma exposure in their work. "PTSD in the nursing population is based on the individual nurse's exposure to traumatic events,

the process of self-healing, and the ability to transform and transcend the experience" (Mealer & Jones, 2013, p. 287). The Nurse as Wounded Healer Theory recognizes that trauma is a universal experience that can lead to consequences that affect all facets of a person, including physical, psychological, emotional, and spiritual. "Trauma experienced by the nurse can involve personal trauma, professional trauma, or a combination of the two. This theory also acknowledges individuals have the capacity to heal trauma by transforming and transcending the experience, allowing for the ability to therapeutically help others" (Mealer & Jones, 2013, p. 280-1). The theory further holds that whether nurses can transcend the impacts of trauma exposure will determine whether they will become "walking wounded" or "wounded healers" (Mealer & Jones, 2013, p. 286).

> Nurses and other health professionals become wounded healers after recognizing, transforming and transcending the pain of trauma in their lives. In the search for wholeness, traumatized individuals may pass from the stage of walking wounded to wounded healer. Wounded healers become able to use themselves therapeutically to help others. This transformation will have a positive impact on the health care system, society and the nursing profession as a whole ("The Theory of the Nurse as Wounded Healer", 2019).

A parallel can be drawn between the experience of adaptation described by the current study's participants, and the transformation described in the theory of 'Nurse as Wounded Healer'. Participants reported they consciously reflected on their experience of exposure to clients' trauma material, that they utilized their knowledge of trauma informed approaches to help them make sense of this experience, and were able to effectively process these experiences through the philosophical lens of TIP. They reported that prior to deepening their understanding of trauma, they lacked the awareness of how trauma may contribute to their clients' behaviour, and were

more likely to be negatively affected by it, for example by personalizing it. Some participants also spoke about developing more compassion for themselves as a result of learning about vicarious trauma as part of the TIP philosophy. This allowed them a framework upon which to become aware of and understand their own reactions to clients' trauma material, and prompted them to focus more on self-care. Participants also described feeling more effective in their work with clients as a result of taking a trauma informed philosophical approach. Nurses who consciously reflected about themselves, their reactions, their philosophical approach, and their values were more likely to experience rewarding aspects of trauma work.

The role of organizations.

In the current study, all participants who were questioned about this topic expressed that the support they have received by their employers to deal with the impacts of secondary trauma exposure has been insufficient, and spoke about the importance of workplace culture and opportunities for debriefing in mitigating negative impacts. Similarly, a participant in Maytum et al.'s (2004) study asserted, "Employers have some responsibility to help nurses recognize and deal with this because it's going to happen, based on the nature of our work" (p. 177). Newall and MacNeil (2010) also stressed the relevance of organizational cultures in supporting those who work with traumatized clients stating,

> Whether or not an agency culture acknowledges the existence of VT, STS, and CF as normal reactions to client traumas may significantly contribute to the coping ability of individuals experiencing these conditions. An accepting organizational culture helps to alleviate stigmas trauma workers may have about experiencing these reactions, such as feeling inadequate or incapable of completing work responsibilities effectively (p. 62).

In van der Wath et al.'s (2013) qualitative exploration of emergency nurses (EN) working with survivors of IPV, the authors suggested that organizations should institute support structures to improve the practice environment for ENs, prevent STS, and ultimately improve the quality of care provided to those experiencing IPV who prevent to the ER. Rourke (2007 as cited in Beck, 2011) identified organizational strategies to reduce STS and CF that include efforts to eliminate the secrecy that exists about these effects, dedicating space for clinicians to meet together, providing resources, formal support teams, and a culture that acknowledges and rewards staff for their difficult work. Pack (2014) asserted that employers have a responsibility to educate helping professionals about the effects of their work with traumatized individuals, to anticipate their support needs, and offer ongoing education and clinical supervision. She further advised that the potential positive impacts of the work should be imbedded in these discussions.

Finally, Gates and Gillespie (2008) identified workplace factors that may reduce the risk of STSD among nurses including debriefing, education, and training. They also discussed the importance of organizational recognition of problems associated with secondary trauma exposure, and the risk of nurses showing signs of STSD becoming "victims in their own workplace" if they are viewed as incompetent or weak as a result of struggling to function in their job because of these symptoms. Gates & Gillespie (2008) also propose that,

> [i]f co- workers or supervisors ignore or deny the problem, the affected nurses are less likely to seek help. Even if the nurse recognizes that he or she is suffering from extreme symptoms of stress, it is unlikely that the nurse will speak up or seek help within the organization if there is a fear of retribution or loss of respect. This lack of action by nurses will have detrimental effects on the nurse, the organization's effectiveness and efficiency, and the quality of patient care (p. 246).

This sentiment was shared by some of the current study's participants who spoke about the lack of recognition of the consequences of trauma exposure in their workplace, and even stigma associated with speaking up about the issue. These findings then confirm the relevance of the current recommendations from the literature to prevent psychological injury that is a result of caring for traumatized individuals, and the critical role of organizations and employers in this prevention.

Significance

The purpose of this research was to examine the lived experiences of RPN's in BC who work with individuals who have experienced trauma. Given the high rates of trauma among individuals seeking treatment for mental health and substance use problems in BC, this is a common experience for RPNs, however their experience been studied minimally. The current research provides new insights into the experience of RPNs, and offers valuable information to individual RPNs, psychiatric nursing educators, and employers about the potential risks and benefits of this aspect of their work.

Implications for psychiatric nurses.

The large majority of the current literature available that discusses the impacts of trauma work on helping professionals has utilized samples of social workers, counselors, and other nursing specialties. This study illuminates the experiences of psychiatric nurses who work with traumatized individuals, and as such offers an invitation for individual RPNs to reflect upon their own experiences, how their work with traumatized individuals has impacted them, and perhaps contributed to the development of their personal and professional identity. The findings may normalize and raise awareness among psychiatric nurses of the consequences that secondary trauma exposure may have, and further shed some light on potential mitigating factors that can be utilized by RPNs who may be struggling with these consequences. Further, while early

theorists and researchers have long suggested a potential for positive aspects of this work (Harrison & Figley, 2009), the focus of the available literature on the subject matter has been on the negative aspects of the experience (Arnold et al., 2005; Barrington & Shakespeare-Finch, 2013). However, the results of this study provide a more optimistic view of the experience of working with trauma survivors that considers the potential for reward and personal and/or professional growth on the part of the psychiatric nurse.

This growth or sense of reward, while common to all RPNs that participated in this study, does not seemingly come without conscious work and the development of a high level of self-awareness and insight. The study's results also highlight the personal responsibility of RPNs to consider their well-being and identify strategies to mitigate or reduce the likelihood of negative consequences of their work with traumatized clients. It is critical that RPNs also consider the identification of their own personal triggers and find ways to process and cope with these actively (Maytum et al., 2004).

The finding that participants' philosophy of psychiatric nursing practice appears to have been fundamentally important to mitigating secondary trauma effects and influencing growth among this group of psychiatric nurses is also of relevance to individual RPNs. This provides hope that enhanced knowledge and adoption of trauma informed approaches may serve to buffer the effects of secondary trauma exposure. This may encourage RPNs to consider their philosophy of care, to seek out additional knowledge and training regarding approaches such as TIP, and advocate for this to be offered by employers.

Implications for psychiatric nursing educators.

Since the inception of concepts to describe the negative impacts of working with traumatized individuals, it has been suggested that one of the key preventative factors involves educating service providers/practitioners (Harrison & Westwood, 2009). Figley (1995)

"considers STS to be a natural, treatable, and preventable consequence of empathic engagement with suffering people. He recognized the importance of warning clinicians in training of the risks associated with caring for the traumatized" (Harrison & Westwood, 2009, p. 204). Beck (2011) advocated for systematic education in which new psychiatric nurses are informed of the risk of VT. Gates and Gillespie (2008) recommended ongoing education about the signs and symptoms of vicarious trauma, including coping behaviors such as emotional numbing and avoidance.

The finding that psychiatric nurses in the current study reported significant benefit as a result of educating themselves about trauma, its impacts, and potential consequences of vicarious exposure is significant to those educating psychiatric nurses. Based on the findings from this study, educating psychiatric nurses in TIP is arguably the most significant way to prevent or reduce the potential for current and long-term negative consequences of trauma work. Robinson et al.'s (2003) findings that RPNs who perceived themselves as having the appropriate skills to work with traumatized individuals scored lower on VT measures reinforces this need for education. If knowledge of trauma and its impacts is key to reducing the negative effects for those nurses involved in trauma work with clients, educators are mandated to provide this knowledge in preparation for practice. Further, TIP knowledge and skills are included as expected entry-level competencies for psychiatric nurses in Canada (RPNRC, 2014). Related competencies include:

1.1.10 Engage in self-care activities to decrease the risk of secondary trauma and burnout.

2.11 Demonstrate knowledge of conceptual models of psychiatric care (e.g., Trauma-Informed Care, Recovery Model, Psychosocial Rehabilitation).

2.16.3 Perform an in-depth psychiatric evaluation (e.g., suicide, history of violence, trauma, stress, mental status, self-perception, adaptation and coping, substance use and abuse).

6.3.2 Recognize and address the impact of societal factors that contribute to mental health and addictions issues (e.g., abuse, poverty, trauma).

6.3.4 Incorporate trauma-informed philosophies and best practices into health care planning.

(RPNRC, 2014)

Psychiatric nursing students require knowledge and skills related to trauma informed principles for licensure as RPNs, and to adequately prepare for practice in our mental health and substance use systems. This study's results serve to strengthen the argument for inclusion of trauma and TIP curriculum in psychiatric nursing education programs in Canada. Courtois (2002) and Courtois and Gold (2009) have acknowledged this gap in core curriculum across a variety of professions in the helping fields including psychology, medicine and mental health, and advocate that education and training in trauma and trauma interventions be included at an undergraduate and graduate level.

Implications for employers.

According to the Mental Health Commission of Canada (2012), organizations have an important role to play in maintaining the mental wellness of public sector employees, which includes psychiatric nurses. They estimate that mental health problems are responsible for 30% of short and long-term disability leaves in Canada, and cost the country more than 6 billion dollars in lost productivity costs, which are attributed to absenteeism and presenteeism (Mental Health Commission of Canada, 2012). Given the increased risks for mental health consequences such as VT and burnout established for mental health professionals including psychiatric nurses,

one could argue these rates are likely higher than in other sectors. “On top of shouldering these costs, employers are increasingly being held legally responsible for psychological health and safety in their workplaces—making them liable to claims” (Mental Health Commission of Canada, 2012, p. 28).

While psychiatric nursing educators play a role in the prevention and/or mitigation of negative effects of working with traumatized individuals, employers are responsible to provide ongoing education, and education for RPNs who have not had trauma or TIP education during their psychiatric nursing training. “Employers play a key role in supporting RPNs to acquire further competencies through orientation, continuing education and professional-development opportunities” (RPNRC, 2014, p. 4). Researchers such as Rourke (2007) have echoed the role of organizations in stopping the silence around nurse exposure to VT, urging employers to offer nurses opportunities to lessen the stress from secondary trauma exposure. Barrington & Shakespeare-Finch (2013) also argued that organizations have an important role in “[re]duction in the risks associated with this work, the enhancement of clinician well-being, and improvement in therapeutic outcomes for clientele are responsibilities” (p. 89). Robinson et al. (2003) reinforce the importance of access to education and opportunities for peer support and team building in reducing VT risk among psychiatric nurses.

Delivery of TIP education for healthcare professionals, including psychiatric nurses, is currently managed primarily by the seven regional health authorities in BC. Education is largely delivered in the form of workshops, seminars and online learning modules, and staff are generally offered these courses on an optional basis, or during orientation only. While several BC health authorities have included the implementation of TIP as a strategic priority (Fraser Health, 2014; Interior Health, 2015; Island Health, 2016; First Nations Health Authority, 2016; Vancouver Coastal Health & Providence Healthcare, 2014), participants in the current study

identified that the trauma and TIP education currently being offered by their employers is insufficient, which is important feedback for organizations employing RPNs in BC. Further, knowledge gained related to the negative impacts associated with working with traumatized individuals may inform organizational efforts to reduce problems of absenteeism and turnover in nurses, which were relevant to five of the six participants in this study.

Strengths and Limitations

This study provides new insights into the experience of psychiatric nurses who work with individuals that have experienced trauma, an area that despite its relevance, has not been examined in Canada. The finding that philosophical approach and trauma and TIP education were key factors influencing psychiatric nurses experience of working with trauma survivors has significant implications for psychiatric nurses, educators, and employers. It further adds to the current literature on the factors that decrease risks for those who engage in therapeutic relationships with traumatized individuals. Finally, the methodology utilized in the study is appropriate and has provided meaningful, rich data that reflect these experiences.

A significant limitation of all research exploring the effects on professionals who work with traumatized individuals, including the current study, is the inherently complex and interwoven aspects of psychiatric nurses' experience. The participants in the current study sometimes found it difficult to separate, for example, the direct experience of working with trauma survivors, from other workplace factors that may contribute to negative outcomes they experience. These include workplace culture, workload, lack of available supports or treatment for clients, staff shortages etc. While the questions posed to participants were intentionally specific to the experience of direct work with trauma survivors, variables such as these are inherently 'lumped together' to form a unified experience. Further, aspects of workplace such as caseload, role, and extent of direct exposure to clients' trauma material were not explored by the

researcher, thereby limiting the potential for identification of variables that contribute to either positive or negative outcomes for psychiatric nurses.

Small sample size and self-selection bias are further limitations of this study. While the researcher sought out nurses with an interest and experience working with traumatized individuals consistent with the methodology used, the participants may have higher degree of awareness, insight, and more experience working with individuals with trauma than the average RPN. It is therefore difficult to generalize the findings to a larger population of RPNs.

Finally, cultural factors were not included in the current study despite the suggestion by Hubbard et al. (2017) that cultural differences between helping professionals and their clients may influence their experience and increase susceptibility to secondary trauma.

Areas for Further Research

Given the scarcity of research that examines the experiences of psychiatric nurses who work with traumatized individuals, there is an abundance of opportunity for future research. For example, more research is needed that examines variances in psychiatric nurses that may serve to either increase their risk of negative consequences or serve as protective factors. “To date, very little is known about the success and satisfaction of clinicians who are able to manage in the workplace despite the potentially noxious demands of their work with traumatized clients” (Harrison & Westwood, 2009, p. 204). While years of experience has come up as a potential protective factor in the existing literature, one has to question whether it is experience alone, or something that clinicians have learned to do in order to better cope with these effects. The finding that philosophy of practice was influential for the RPNs in this study should be explored in future research. Likewise, the role of reflective practice is an area the merits further exploration. As Hubbard et al. (2017) ascertain,

> The nurse's ability to consider his or her degree of immersion and experience of vulnerability may provide initial markers for risk for ST. Further, self- reflection by the nurse about the extent of empathic engagement and the intensity of his or her personal reaction can provide additional information about the potential for a positive transformation or negative (ST) outcome. Failure to recognize ST may compromise the nurse's ability to maintain a work–life balance and to provide quality patient care (p. 124).

Psychiatric nurses' own trauma experiences also were identified as having relevance to the majority of participants in the current study. Further research is needed to determine the relationship between psychiatric nurses' trauma and their experience working with trauma survivors. While existing research has pointed to personal trauma as a risk factor for developing VT or STS, the current study's participants identified this as a source of potential strength in some cases. It is therefore important that future research explore this relationship in more depth.

With regards to educational and organizational factors, it is important that more research be undertaken that examines the effectiveness of current education, clinical supervision, and supports given to psychiatric nurses, as the majority of the current study's participants described these aspects of their work and training as insufficient. Further, it may be that certain work environments or practice areas carry more significant risks for psychiatric nurses. For example, researches have demonstrated that care providers who witness children's trauma are prone higher than average levels of secondary traumatic stress (Berger et al., 2015). Identifying high risk work environments will inform organization efforts to better support psychiatric nurses.

Chapter 6: Conclusion

There is a concerning lack of available literature that explores the experiences of psychiatric nurses in Canada who work with traumatized individuals, despite increasing recognition of the potential for negative effects of this work within other nursing specialties and related disciplines, along with the high rates at which psychiatric nurses are exposed to secondary trauma material. The current study sought to add to the limited knowledge available by addressing the research question, *what are the lived experiences of psychiatric nurses who work with traumatized individuals?* Hermeneutic phenomenology was selected as the most appropriate research methodology to address this question, given the goal was to obtain rich data about the meaning of these experiences, its relevance to issues central to the nursing discipline, and the researcher's own relationship to the subject matter (Johnston, Wallis, Oprescu & Gray, 2016; Sloan & Bowe, 2014). Six RPNs were recruited via purposeful sampling and were interviewed in a semi-structured manner about their experiences working with trauma survivors. These interviews were audio-recorded and transcribed by the researcher, and analysis of transcripts was undertaken using Crist and Tanner's (2003) framework. Themes that emerged from the data were: awareness of trauma prevalence among clients, participants' personal trauma, negative impacts of working with traumatized clients, positive impacts of working with traumatized clients, protective factors, shifts in philosophy of practice, and lack of organizational supports. Sub-themes were further identified under participants' personal trauma, negative and positive impacts of working with traumatized clients, and protective factors.

The data obtained from six RPNs in the current study is well-aligned with the current literature from other disciplines and nursing specialties that addresses both positive and negative impacts that may occur as a result of exposure to clients' trauma material. Evidence from the

study suggests self-care, seeking support, trauma and TIP education, and organizational support are of particular importance in mitigating the negative effects of secondary trauma exposure, consistent with the current research literature. The theme that one's philosophy of practice had relevance to the majority of the study's participants is a new finding that lends itself to further exploration.

The study's findings have implications on three levels: individuals RPNs, educators, and organizations. RPNs may benefit from understanding how the RPNs in this study viewed their work with traumatized clients as a means of normalizing their own experience, and may gain increased awareness of their own responses to this experience. Further, RPNs may be inspired to consider their own coping strategies and approaches to practice that may prevent or lessen the negative effects of this work. Importantly, they may also benefit from awareness of the potential positive rewards of their work with traumatized individuals, and how the study's participants find positive meaning in their experience.

The findings from this study also have relevance to psychiatric nursing educators, given the finding that all RPNs in this study felt under-educated and unprepared to work with trauma survivors at the outset of their career, identifying that they had to seek out their own knowledge and training in order to practice competently in this aspect of their work. This finding speaks to the importance of prevention of negative consequences of secondary trauma exposure and education as a key aspect in this prevention. Psychiatric nursing educators should consider inclusion of trauma and TIP curricula in undergraduate programs given the available literature (including this study) that cites it as an important component of maintaining wellness among practitioners who work with traumatized individuals.

Finally, organizations and employers may benefit from the knowledge that the RPN

participants in this study do not feel adequately supported to cope with their work with trauma survivors in the existing frameworks. Further, they may benefit from awareness of the suggestions from these RPNs about ways to improve their perceived level of support; for example by offering more in-depth training or education pertaining to trauma and/or TIP, and more opportunities for debriefing. It should be of relevance to employers that the majority of participants interviewed have reported alterations in work performance including absenteeism and leaving positions as a result of the negative effects of working with trauma survivors, a finding that has relevance to employers' efforts to retain qualified RPNs. The finding that some participants reported an increase in substance use may also be of significance to employers.

Research on the experiences of psychiatric nurses experience their work with trauma survivors is scare, and there is therefore an abundance of opportunity to research various aspects of this experience further. Further research should explore prevention and mitigating factors for secondary traumatic stress to promote the well-being of RPNs, and ultimately the clients they serve. The finding that philosophy of practice is influential in shifting negative outcomes to positive ones is a novel finding that would benefit from being explored in more depth.

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Appendix A

Recruitment Advertisement

BRANDON UNIVERSITY

RPN Research Participants Wanted

Nicole Nicholas, Master of Psychiatric Nursing candidate at Brandon University, is looking for RPN volunteers to take part in a qualitative research study exploring the experiences of RPNs who work with individuals who have a history of trauma. Participation in this study is anonymous involving an initial 60-minute interview, with brief follow-up interview to clarify and confirm details as needed. This study has been reviewed by, and received ethics approval from Brandon University Research Ethics Committee. For more information about this study, or to participate in this study, please contact: nicholnm48@brandonu.ca

Appendix B

E-mail to Interested Participants

Thank you for your interest in participating in my research study. The purpose of this email is to provide you with further information regarding the project and your role as a participant.

My name is Nicole Nicholas and I am an RPN and graduate student in the Master of Psychiatric Nursing program at Brandon University. My research interest is the experience of psychiatric nurses who work with individuals who have experienced trauma, and the potential personal and professional impacts of this work.

For my graduate thesis I will be conducting qualitative research with a focus on this topic. I am therefore interested in interviewing RPN's who have experience working with traumatized individuals, and who are willing to share their experiences in one to one interview format. The goal of this research is to add to what little is known about how psychiatric nurses experience this role, and to inform psychiatric nursing practice, education, and healthcare policy.

Participation in this study is completely voluntary, and participants can withdraw their participation at any point during the study. All efforts will be made to maintain participants' anonymity and confidentiality. Participation will involve being interviewed by myself in a private, mutually agreed upon location. One initial interview will last approximately 60 minutes, during which you will be asked questions about your experience working with traumatized individuals and how this has impacted you. You may be asked to participate in one to two

follow-up interviews of approximately 15-30 minutes to clarify and/or confirm initial details from the first interview.

Should you have any questions pertaining to this study or would like to confirm your interest in participating, please feel free to contact me at **nicholnm48@brandonu.ca** or by phone at 604-809-2624.

Thank you,

Nicole Nicholas RPN, BA, MPN (cand.)

Appendix C

Demographic Collection Tool

BRANDON UNIVERSITY

DEMOGRAPHIC INFORMATION

1. PARTICIPANT NUMBER: _____
2. GENDER: _____
3. AGE: _____
4. NURSING EDUCATION:

   COUNTRY: _____

   PROVINCE (IF CANADA) : _____

   ( ) DIPLOMA YEAR COMPLETED: _____

   ( ) DEGREE YEAR COMPLETED: _____

   OTHER RELATED EDUCATION:

   _____

5. YEARS OF PRACTICE EXPERIENCE: _____
6. AREAS OF PRACTICE EXPERIENCE:

   ( ) ADULT ACUTE PSYCHIATRY

( ) COMMUNITY MENTAL HEALTH

( ) SUBSTANCE USE/CONCURRENT DISORDERS

( ) FORENSIC PSYCHIATRY

( ) CHILD & YOUTH ACUTE PSYCHIATRY

( ) CHILD & YOUTH COMMUNITY MENTAL HEALTH

( ) EMERGENCY/CRISIS RESPONSE

( ) OTHER: _____

7. CURRENT ROLE: _____
8. HEALTH AUTHORITY/REGION: _____

Appendix D

Consent for Participation in Research

By signing this consent form I am agreeing to participate in a research project conducted by master of Psychiatric Nursing student Nicole Nicholas under the supervision of Dr. Dean Care, both from Brandon University.

I understand the objective of the study is to add to the existing knowledge of how psychiatric nurses experiences their work with traumatized individuals, and agree to be interviewed about my own experiences as an RPN working with individuals who have experienced trauma.

I understand that my participation in this project is voluntary and that I will not be paid for my participation. I may withdraw and discontinue participation at any time without penalty. If I feel uncomfortable in any way during the interview session, I have the right to decline to answer any question or to end the interview.

I understand that my participation will involve being interviewed by the principle researcher once for approximately 60 minutes, with a maximum of two additional follow-up interviews of a maximum of 30 minutes to clarify and confirm initial interview findings. I understand that interviews will be conducted in a private location agreed upon by me prior to the initiation of the interview(s).

I consent to the audio recording of all interviews and understand that notes will be written by the researcher during the interview(s).

I understand that the researcher will not identify me by name in any reports using information obtained from this interview, and that my confidentiality as a participant in this study will remain secure.

I understand that this research study has been reviewed and approved by the Brandon University Research Ethics Committee (BUREC) and that I can contact BUREC with any questions concerning the study at BUREC@BRANDONU.CA

I have read and understand the explanation provided to me regarding my participation in this study. I have had all my questions answered to my satisfaction, I voluntarily agree to participate in this study, and have been given a copy of this consent form.

_____	_____
Participant's Printed Name	Date
_____	_____
Participant's Signature	Signature of the Researcher

Appendix E

Interview Guide

1) During your career as an RPN, tell me about your exposure to clients who have experienced trauma.
2) When you consider the work you have done with these clients, what stands out for you in terms of your own experience?
3) How have you been affected personally by your work with clients who have experienced trauma?

   *If response include negative impacts:

   a. In what ways have these effects impacted your personal life?
   b. What has helped you to cope with these effects?
4) How has your work with traumatized clients impacted you professionally?

   *If response includes negative impacts:

   a. Have these effects made doing your job more difficult? If yes, how?
   b. Have these effects caused you to be absent from work?
   c. Have these effects caused you to consider changing positions?
   d. What has helped you cope with these effects?
   e. What role (if any) has your employer or other workplace supports had on assisting you to cope with these effects?
   f. What workplace changes or additional supports would you suggest might help you cope with these effects of working with traumatized clients?
5) Can you identify any positive impacts this work has had on you personally?

6) What if any positive impacts has your work with traumatized clients had on your nursing practice?

7) Please tell me about any education or training you have received pertaining to trauma or trauma-informed practice.

Appendix F

BUREC Ethics Certificate

BRANDON UNIVERSITY

Brandon University Research Ethics Committee (BUREC) Ethics Certificate for Research Involving Human Participants

The following ethics proposal has been approved by the BUREC. **Ethics Certification is valid for up to five (5) years from the date approved, pending receipt of Annual Progress Reports.** As per *BUREC Policies and Procedures*, section 6.0, "At a minimum, continuing ethics research review shall consist of an Annual Report for multi-year projects and a Final Report at the end of all projects... Failure to fulfill the continuing research ethics review requirements is considered an act of non-compliance and may result in the suspension of active ethics certification; refusal to review and approval any new research ethics submissions, and/or others as outlined in Section 10.0".

Any changes made to the protocol must be reported to the BUREC prior to implementation. See *BUREC Policies and Procedures* for more details.

As per *BUREC Policies and Procedures*, section 10.0, "Brandon University requires that all faculty members, staff, and students adhere to the *BUREC Policies and Procedures*. The University considers non-compliance and the inappropriate treatment of human participants to be a serious offence, subject to penalties, including, but not limited to, formal written documentation including permanently in one's personnel file, suspension of ethics certification, withdrawal of privileges to conduct research involving humans, and/or disciplinary action."

Principal Investigator: Ms. Nicole Nicholas, Brandon University

Title of Project: An Examination of the Experiences of Psychiatric Nurses Who Work with Traumatized Individuals

Co-Investigators: n/a

Faculty Supervisor: Dr. W. Dean Care, Brandon University

Research Ethics File #: 22301

Date of Approval: July 12, 2018

Ethics Expiry Date: July 12, 2023

Authorizing Signature:

Mr. Christopher Hurst
Co-Chair, Brandon University Research Ethics Committee (BUREC)

270 18th Street, Brandon MB, Canada R7A 6A9 204.727.9712 **BrandonU.ca**